HANDBOUND
AT THE
UNIVERSITY OF
TORONTO PRESS

Digitized by the Internet Archive
in 2010 with funding from
University of Toronto

http://www.archive.org/details/transactions16path

7757

TRANSACTIONS

OF THE

PATHOLOGICAL SOCIETY OF LONDON.

VOLUME SIXTEENTH.

COMPRISING THE REPORT OF THE PROCEEDINGS FOR THE SESSION 1864-65.

LONDON:

PRINTED FOR THE SOCIETY BY J. W. ROCHE, 68, PARADISE STREET, ROTHERHITHE.

1865.

RB
1
P2
v.16

The present publication, being the Sixteenth Volume of Transactions, constitutes the Nineteenth published Annual Report of the Pathological Society's proceedings.

The Council think it right to repeat, that the exhibitors are alone responsible for the descriptions given of the Specimens exhibited by them, the only change made in the Reports furnished by the authors being such verbal alterations as were absolutely necessary.

53, Berners Street, Oxford Street,
September, 1865.

7646

TABLE OF CONTENTS

OF VOLUME XVI.

List of Presidents and of Officers and Members during the Session 1864-65 1

List of Specimens Exhibited during the Session 1864-65 xix

List of Plates xlii

List of Woodcuts xliii

Diseases, etc., of the Nervous System 1

Diseases, etc., of the Organs of Respiration . . . 37

Diseases, etc., of the Organs of Circulation . . . 62

Diseases, etc., of the Organs of Digestion . . . 124

Diseases, etc., of the Genito-Urinary Organs . . 164

Diseases, etc., of the Osseous System 212

Diseases, etc., of the Organs of Special Sense . . 230

Tumours. 236

Diseases, etc., of the Ductless Glands 242

Diseases, etc., of the Skin 254

Miscellaneous Specimens 272

Specimens from the Lower Animals 279

Index. 283

Former Presidents.

ELECTED	
1846	CHARLES J. B. WILLIAMS, M.D., F.R.S.
1848	CHARLES ASTON KEY, Esq.
1850	PETER MERE LATHAM, M.D.
1852	CÆSAR H. HAWKINS, Esq., F.R.S.
1853	BENJAMIN GUY BABINGTON, M.D., F.R.S.
1855	JAMES MONCRIEFF ARNOTT, Esq., F.R.S.
1857	THOMAS WATSON, M.D., F.R.S.
1859	WILLIAM FERGUSSON, Esq., F.R.S.
1861	JAMES COPLAND, M.D., F.R.S.
1863	PRESCOTT G. HEWETT, Esq.

OFFICERS AND COUNCIL

OF THE

Pathological Society of London,

ELECTED AT

THE GENERAL MEETING, JANUARY 3, 1865.

President.

THOMAS BEVILL PEACOCK, M.D.

Vice-Presidents.

THOMAS A. BARKER, M.D.
A. B. GARROD, M.D., F.R.S.
JOHN W. OGLE, M.D.
EDWARD H. SIEVEKING, M.D.
CHARLES BROOKE, Esq., F.R.S.
PRESCOTT G. HEWETT, Esq.
GEORGE D. POLLOCK, Esq.
JOSEPH TOYNBEE, Esq., F.R.S.

Treasurer.

RICHARD QUAIN, M.D.

Council.

JOHN S. BRISTOWE, M.D.
GEORGE BUCHANAN, M.D.
ANDREW CLARK, M.D.
GEORGE D. GIBB, M.D.
STEPHEN J. GOODFELLOW, M.D.
GEORGE HARLEY, M.D., F.R.S.
GRAILY HEWITT, M.D.
JOHN RANDALL, M.D.
J. BURDON SANDERSON, M.D.
CHARLES A. AIKIN, Esq.
THOMAS BRYANT, Esq.
GEORGE W. CALLENDER, Esq.
JOHN WHITAKER HULKE, Esq.
SYDNEY JONES, Esq., M.B.
THOMAS WILLIAM NUNN, Esq.
EDWARD RAY, Esq.
SEPTIMUS W. SIBLEY, Esq.
HENRY THOMPSON, Esq.
JOHN W. TROTTER, Esq.
T. SPENCER WELLS, Esq.

Honorary Secretaries.

CHARLES MURCHISON, M.D. | TIMOTHY HOLMES, Esq.

Trustees.

THOS. BEVILL PEACOCK, M.D. | RICHARD QUAIN, M.D.
GEORGE POLLOCK, Esq.

*** *Members are requested to indicate to the Secretaries corrections when necessary.*

LIST OF MEMBERS OF THE SOCIETY.

Honorary Members.

Andral, G., M.D., Professor in the Faculty of Medicine, Paris.

Cruveilhier, J. C., M.D., Professor in the Faculty of Medicine, Paris.

Henle, J. Professor of Anatomy and Physiology in the University of Zurich.

Rokitansky, Carl, M.D., Professor of Pathological Anatomy in the University of Vienna.

Stokes, William, M.D., D.C.L., LL.D., F.R.S., M.R.I.A., Regius Professor of Physic in the University of Dublin, Physician in Ordinary to the Queen in Ireland.

Vogel, Julius, M.D., Professor of Clinical Medicine in the University of Giessen.

Resident and Non-Resident Members.

(C.) Present Members of Council.

† Have paid Composition Fee for Annual Subscriptions.

* Former Members of Council.

‡ Have paid Composition Fee for Transactions.

GENERAL LIST OF MEMBERS.

Elected Session

1858-59 Acland, Henry Wentworth, M.D., F.R.S., Physician to the Radcliffe Infirmary, Oxford.

**Orig. Memb.* Adams, William, Esq., Surgeon to the Royal Orthopædic Hospital, 5, Henrietta-street, Cavendish-square.

1858-59 Adams, William, Esq., 37, Harrington-square.

1847-48 Aikin, Charles, A., Esq. (C.), 7, Clifton-place, Sussex-square, Hyde-park.

1857-58 Alison, S. Scott, M.D., Physician to the Hospital for Consumption, Brompton, 80, Park-street, Grosvenor-square.

1863-64 Allingham, William, Esq., Surgeon to the Farringdon Dispensary, 36, Finsbury-square.

1859-60 Andrew, Edwyn, M.D., Windsor-house, Shrewsbury.

1862-63 Andrew, James, M.D., Assistant Physician and Warden of the College, St. Bartholomew's Hospital.

1857-58 Anstie, Francis E., M.D., Assistant-Physician to the Westminster Hospital, 16, Wimpole-street.

**Orig. Memb.* Arnott, James Moncrieff, Esq., F.R.S. (formerly President).

Elected Session

1851-52 Ashton, T. J., Esq., Consulting-Surgeon to the St. Marylebone Infirmary, 31, Cavendish-square.

1857-58 Avent, Nicholas, Esq., Modbury, Devonshire.

**Orig. Memb.* Babington, Benjamin Guy, M.D., F.R.S. (formerly President), 31, George-street, Hanover-square.

1863-64 Bagshawe, Frederick, Esq., M.A., M.B. Cant., 21, Connaught-square.

1864-65 Baker, William Morrant, Esq., Demonstrator of Anatomy at St. Bartholomew's Hospital, 6, Furnival's-inn.

1856-57 Balding, Daniel Barley, Esq., Royston, Herts.

*1849-50 Ballard, Thomas, M.D., 10, Southwick-place, Hyde-park.

1864-65 Bankart, James, Esq., M.B., Demonstrator of Anatomy, Guy's Hospital, 10, Trinity-square, Southwark.

*1851-52 Barclay, A. Whyte, M.D., Physician to St. George's Hospital, 23A, Bruton-street, Berkeley-square.

1860-61 Barker, Edgar, Esq., Jun., 5, Albion-place, Hyde-park.

*1855-56 Barker, T. A., M.D. (V.P.), Senior Physician to St. Thomas's Hospital, 27, Wimpole-street.

Orig. Memb. Barker, Thomas Herbert, M.D., Harpur-place, Bedford.

**Orig. Memb.* Barlow, George Hilaro, M.D. (late V.P.), Physician to Guy's Hospital, 12, Union-street, Southwark.

1852-53 Bartlett, William, Esq., Surgeon to the Kensington Dispensary, Ladbroke Lodge, Ladbroke-square, Notting-hill.

1862-63 Barratt, Joseph Gillman, Esq., 22, Cleveland-gardens, Bayswater.

*1852-53 Barwell, Richard, Esq., Assistant-Surgeon to the Charing Cross Hospital, 32, George-street, Hanover-square.

1857-58 Basham, William R., M.D., Senior Physician to the Westminster Hospital, 17, Chester-street, Grosvenor-place.

1861-62 Bastian, H. C., Esq., M.A., Broadmoor, Wokingham.

*1851-52 Beale, Lionel S., M.B., F.R.S., Physician to King's College Hospital, 61, Grosvenor-street.

1855-56 Bealey, Adam, M.D., M.A., 27, Tavistock-square.

1852-53 Beck, Thomas Snow, M.D., F.R.S., 71, Portland-place, W.

1864-65 Beigel, Hermann, M.D., 19, Woburn-place.

*1849-50 Beith, Robert, M.D., Deputy Inspector-General of Jamaica Hospitals.

1862-63 Bell, James B., Esq., 30, Margaret-street, Cavendish-square.

1864-65 Bellamy, Edward, Esq., 9, New Ormond-street.

1846-47 Bennet, James Henry, M.D., Weybridge, Surrey.

**Orig. Memb.* Bennett, James Risdon, M.D. (formerly V.P.), Physician to St. Thomas's Hospital and to the City of London Hospital for Diseases of the Chest, 15, Finsbury-square.

‡1856-57 Bickersteth, Edward R., Esq., Surgeon to the Liverpool Royal Infirmary, 2, Rodney-street, Liverpool.

1855-56 Bird, W., Esq., Surgeon to the West London Hospital, 7, George-street, Hanover-square.

*1849-50 Birkett, Edmund Lloyd, M.D., Physician to the City of London Hospital for Diseases of the Chest, 48, Russell-square.

Elected Session

Orig. Memb. Birkett, John, Esq. (late V.P.), Surgeon to Guy's Hospital, 59, Green-street, Grosvenor-square.

1853-54 Black, Cornelius, M.D., Physician to the Chesterfield Dispensary, St. Mary's-gate, Chesterfield.

1849-50 Blagden, Robert, Esq., Stroud, Gloucestershire.

1863-64 Blanchet, Jean B., M.D., M.S., Montreal, Quebec, Canada.

1863-64 Bowen, Francis, M.D., 62, Upper Berkeley-street, Portman-square.

1861-62 Bower, Richard Norris, Esq., 14, Doughty-street, Mecklenburg-square.

*1850-51 Bowman, William, Esq., F.R.S., Surgeon to the Royal Ophthalmic Hospital, 5, Clifford-street.

1862-63 Braine, Francis Woodham, Esq., 44, Hertford-street, May-fair.

*1846-47 Brinton, William, M.D., F.R.S., 24, Brook-street, Grosvenor-square.

1856-57 Briscoe, John, Esq., 12, Broad-street, Oxford.

*†1850-51 Bristowe, John S., M.D. (C.) (late Hon. Secretary), Physician to St. Thomas's Hospital, 2, Queen-square, Westminster.

1859-60 Broadbent, William Henry, M.D. Lond., Assistant-Physician to St. Mary's Hospital, and to the London Fever Hospital, 23, Upper Seymour-street, Portman-square.

*1851-52 Brodhurst, Bernard E., Esq., Assistant-Surgeon to St. George's Hospital, and to the Royal Orthopædic Hospital, 20, Grosvenor-street.

1863-64 Brodie, George Bernard, M.D., 10, Bolton-row, May-fair.

*1846-47 Brooke, Charles, M.B., F.R.S. (V.P.), Surgeon to the Westminster Hospital, 16, Fitzroy-square.

1864-65 Brown, Augustus, M.D., 30, Belitha-villas, Barnsbury-park.

Orig. Memb. Browne, Joseph Hullett, M.D., Physician to the St. Pancras Royal General Dispensary, 55, Gordon-square.

1854-55 Browne, Robert Cave, M.D., Armley-lodge, Barnet, Herts.

1859-60 Browning, Charles, M.D., 52, Portsdown-road, Maida-hill.

1859-60 Browning, George, M.D., 10, St. Stephen's-crescent, Westbourne-park.

1855-56 Bryant, Thomas, Esq. (C.), Assistant-Surgeon to Guy's Hospital, 2, Finsbury-square.

1854-55 Buchanan, George, M.D. (C.), Physician to the London Fever Hospital, and Assistant-Physician to the Hospital for Sick Children, 63, Harley-street, Cavendish-square.

1861-62 Buchanan, Albert, M.B. Lond., 11A, Myddelton-square.

1858-59 Buckland, Francis, Esq., late Surgeon to the 2nd Regiment of Life Guards, 156, Albany-street.

*1858-59 Budd, George, M.D., F.R.S., 20, Dover-street, Piccadilly.

1850-51 Bullock, Henry, Esq., 61, Cumberland-street, Bryanstone-square.

1859-60 Burton, Alfred, Esq., 13, Dover-street, Piccadilly.

1852-53 Burton, John M., Esq., Lee-park-lodge, Lee, Kent.

Orig. Memb. Busk, George, Esq., F.R.S. (late V.P.), Surgeon to the Seamen's Hospital-ship, "Dreadnought," 15, Harley-street, Cavendish-square.

1856-57 Buzzard, Thomas, M.D., 12, Green-street, Park-lane.

1856-57 Callender, G. W., Esq. (C.), Assistant-Surgeon to St. Bartholomew's Hospital, 17, Queen Anne-street, Cavendish-square.

Elected Session

‡1862-63 Campbell, Charles, M.D., Kingston, Jamaica.

*†*Orig. Memb.* Camps, William, M.D., 40, Park-street, Grosvenor-square.

*1849-50 Canton, Edwin, Esq., Surgeon to the Charing Cross Hospital, 30, Montague-place, Russell-square.

‡1854-55 Carpenter, Alfred, M.D., High-street, Croydon.

1848-49 Carpenter, William Guest, Esq., Amersham, Bucks.

1861-62 Carr, William, Esq., F.R.C.S., Lee, Blackheath.

1855-56 Carter, H. V., M.D., Professor of Anatomy and Physiology, Grant Medical College, Bombay.

1863-64 Cay, Charles Vidler, Esq., Coldstream Guards Hospital, Vincent-square, Westminster.

1863-64 Cayley, William, M.D., Demonstrator of Morbid Anatomy at the Middlesex Hospital, 10, Maddox-street.

*1848-49 Chalk, William Oliver, Esq., 3, Nottingham-terrace, Regent's-park.

**Orig. Memb.* Chevers, Norman, M.D., India.

‡1858-59 Child, Gilbert W., M.D., Physician to the Radcliffe Infirmary, 61, St. Giles', Oxford.

1851-52 Childs, George Borlase, Esq., Surgeon to the Metropolitan Free Hospital, and to the City Police Force, 11, Finsbury-place South.

1854-55 Cholmeley, William, M.D., Physician to the Great Northern Hospital, 40, Russell-square.

*1851-52 Chowne, William D., M.D., Physician to the Charing Cross Hospital, 8, Connaught-place West, Hyde-park.

1860-61 Clapton, Edward, M.D., 4, St. Thomas's-street, Southwark.

1853-54 Clark, Andrew, M.D. (C.), Assistant-Physician to the London Hospital, 23, Montague-place, Russell-square.

1864-65 Clarke, Jacob Lockhart, Esq., F.R.S., 60, Warwick-street, Pimlico.

*1849-50 Clarke, John, Esq., L.R.C.P., Physician-Accoucheur to the British Lying-in-Hospital, and to the General Lying-in-Hospital, 42, Hertford-street, May-fair.

**Orig. Memb.* Cock, Edward, Esq. (late V.P.), Surgeon to Guy's Hospital, Dean-street South, Tooley-street.

1857-58 Cockerton, Richard, Esq., Surgeon to the Kensington Dispensary, 12, Petersham-terrace, Gloucester-road, South Kensington.

1855-56 Cockle, John, M.D., M.A., Physician to the Royal Free Hospital, 63A, Brook-street, Hanover-square.

Orig. Memb. Cohen, Daniel Whitaker, M.D.

1858-59 Cooke, Robert Thomas, Esq., Surgeon to the Scarborough Dispensary, 15, St. Nicholas Cliff, Scarborough, Yorkshire.

*1850-51 Cooper, William White, Esq., Consulting Ophthalmic Surgeon to St. Mary's Hospital, 19, Berkeley-square.

**Orig. Memb.* Copland, James, M.D., F.R.S. (late President), Consulting Physician to the Royal Infirmary for Children, 5, Old Burlington-street.

1853-54 Cornish, William Robert, Esq.

1858-59 Coulson, Walter J., Esq., Surgeon to the Lock Hospital, and Surgical Registrar to St. Mary's Hospital, 29, St. James's-place.

**Orig. Memb.* Coulson, William, Esq. (late V.P.), Consulting Surgeon to St. Mary's Hospital, 1, Chester-terrace, Regent's-park.

Elected Session

†1861-62 Couper, John, Esq., Assistant-Surgeon to the London Hospital, 33, Finsbury-circus.

1852-53 Cousins, Edward, Esq., 49, Camden-road-villas, Camden-town.

**Orig. Memb.* Crisp, Edwards, M.D., 21, Parliament-street.

*1848-49 Critchett, George, Esq., Surgeon to the Royal London Ophthalmic Hospital, Moorfields, 75, Harley-street.

1855-56 Croft, John, Esq., Surgeon to the Surrey Dispensary, 6, Great Dover-road, Southwark.

1860-61 Crosby, Thomas Boor, Esq., 23, Finsbury-place.

1853-54 Cross, Robert, M.D., Physician to the Brewer's-court Dispensary, 20, New-street, Spring-gardens.

1864-65 Crucknell, Henry, Esq., M.B., 7, Prince's-street, Hanover-square.

1857-58 Cumberbatch, Laurence T., Esq., 25, Cadogan-place, Sloane-street.

1854-55 Curgenven, J. Brendon, Esq., 11, Craven-hill-gardens, Bayswater.

*1854-55 Curling, Thomas Blizard, Esq., F.R.S., Surgeon to the London Hospital, 39, Grosvenor-street.

1863-64 Dane, Thomas, Esq., 24, New Finchley-road.

**Orig. Memb.* Davies, Herbert, M.D., Consulting Physician to the Infirmary for Asthma, &c., and Physician to the London Hospital, 23, Finsbury-square.

*1846-47 Davis, John Hall, M.D., Physician Accoucheur to the Middlesex Hospital, and to the Royal Maternity Charity, 11, Harley-street, Cavendish-square.

‡1859-60 Davis, Francis William, Esq., R.N., 11 and 12, Love-lane, Aldermanbury.

**Orig. Memb.* Day, George E., M.D., F.R.S., Emeritus Professor of Medicine in the University of St. Andrews.

1857-58 Delima, Teofilo, M.D., Caracas, South America.

1851-52 Devenish, Samuel Weston, M.B., 7, Billiter-square.

1862-63 Devereux, Daniel, Esq., Tewkesbury.

1861-62 Diamond, W. H., L.R.C.P. Edinb., Resident-Physician of the Lunatic Asylum, Brixton.

1855-56 Dick, H., M.D., 59, Wimpole-street, Cavendish-square.

1858-59 Dickinson, W. H., M.D., Curator of the Pathological Museum at St. George's Hospital, and Assistant-Physician to the Hospital for Sick Children, 11, Chesterfield-street, May-fair.

**Orig. Memb.* Dixon, James, Esq. (late V.P.), Surgeon to the Royal Ophthalmic Hospital, Moorfields, 2, Portman-square.

1864-65 Duckworth, Dyce, M.D., 70, Wimpole-street.

1863-64 Dudfield, Thomas Orme, M.D., 8, Upper Phillimore-place, Kensington.

1846-47 Dudgeon, Robert E., M.D., 53, Montagu-square.

1851-52 Duff, George, M.D., High-street, Elgin.

1860-61 Dunn, Robert William, Esq., 31, Norfolk-street, Strand.

1864-65 Du Pasquier, Claudius Francis, Esq., Surgeon-Apothecary to the Queen, 62, Pall-mall.

1858-59 Durham, Arthur Edward, Esq., Assistant-Surgeon to Guy's Hospital, 30, Brook-street, Grosvenor-square.

Elected Session

1848-49 Eden, Thomas E., Esq., Surgeon-Dentist to the Farringdon General Dispensary, 45, Threadneedle-street.

1854-55 Edwards, George N., M.D., Assistant-Physician to St. Bartholomew's Hospital, 1, Finsbury-square.

1846-47 Ellis, Joseph, Esq., Sudbrook-park, Richmond, Surrey.

*1846-47 Erichsen, John, Esq. (late V.P.), Surgeon to University College Hospital, 6, Cavendish-place, Cavendish-square.

1853-54 Evans, Conway, M.D., Assistant-Physician to King's College Hospital, 56, Russell-square.

‡1858-59 Ewens, John, Esq., Milton-Abbas, Blandford, Dorset.

1864-65 Fagge, Charles Hilton, M.D., Demonstrator of Anatomy at Guy's Hospital, 43, Trinity-square, Southwark.

1861-62 Farquharson, Robert, M.D., Assistant-Surgeon, Coldstream Guards Hospital, Vincent-square, Westminster.

1863-64 Fenwick, Samuel, M.D., Assistant-Physician to the City of London Hospital for Diseases of the Chest, 74, Harley-street.

*1847-48 Fergusson, William, Esq., F.R.S. (formerly V.P., late President), Surgeon to King's College Hospital, 16, George-street, Hanover-square.

*1846-47 Fincham, George T., M.D., Physician to the Westminster Hospital, 2, Eccleston-terrace South, Eccleston-square.

1853-54 Fisher, W. Webster, M.D., Downing Professor of Medicine, Cambridge.

1859-60 Fisher, Alexander, M.D., Assistant-Surgeon, R.N., Her Majesty's Ship "Dragon," Chatham.

*1855-56 Flower, William H., Esq., F.R.S., Conservator of the Museum, Royal College of Surgeons, Lincoln's-inn Fields.

*1851-52 Forbes, J. Gregory, Esq., Surgeon to the Metropolitan Convalescent Institution, 9, Devonport-street, Hyde-park.

1849-50 Foreman, Robert Clifton, M.D., Resident Physician to the Asylum for Imbecile Children of the Upper Classes, Church-hill House, Brighton.

*†*Orig. Memb.* Forster, John Cooper, Esq., Assistant Surgeon to Guy's Hospital, Surgeon to the Royal Infirmary for Children, 10, St. Thomas's-street, Southwark.

1859-60 Foster, Michael, Jun., M.D., Huntingdon.

1862-63 Fox, Wilson, M.D., Assistant-Physician to University College Hospital, 24, Henrietta-street, Cavendish-square.

1858-59 Francis, Charles Richard, M.B., Bengal Medical Establishment, Indian Army.

1853-54 Freeman, William Henry, Esq., 21, Spring-gardens.

Orig. Memb. Frere, J. C., Esq., Trinity College, Cambridge.

1863-64 Frodsham, John Mill, M.D., Physician to St. John's Hospital for Diseases of the Skin, 17, Victoria-square, Pimlico.

*1846-47 Fuller, Henry W., M.D., Physician to St. George's Hospital, 13, Manchester-square.

‡1858-59 Gairdner, William Tennant, M.D., Professor of Medicine in the University of Glasgow, 21, Blythswood-square, Glasgow.

Elected Session

1860-61 Galton, Robert Cameron, M.D. Camb., Hadzor-house, Droitwich.

1855-56 Gamgee, Joseph Sampson, Esq., Surgeon to the Queen's Hospital, Birmingham, 20, Broad-street, Birmingham.

1855-56 Gamgee, J. Esq., Albert Veterinary College, Queen's-road, Bayswater.

1850-51 Garrett, Mark Brown, Esq., 3, New-road, St. George's East.

*1846-47 Garrod, Alfred Baring, M.D., F.R.S. (V.P.), Physician to King's College Hospital, 84, Harley-street, Cavendish-square.

1855-56 Gaskoin, George, Esq., 3, Westbourne-park, Paddington.

**Orig. Memb.* Gay, John, Esq., Senior Surgeon to the Great Northern Hospital, King's-cross, 10, Finsbury-place South.

1854-55 Gibb, George Duncan, M.D., F.G.S. (C.), Assistant-Physician to the Westminster Hospital, 19A, Portman-street, Portman-square.

1853-54 Gibbon, Septimus, M.D., 3, Finsbury-square.

‡1857-58 Godfrey, Benjamin, M.D., Carlton-house, Enfield.

1854-55 Goodfellow, Stephen Jennings, M.D. (C.), Physician to the Middlesex Hospital, 5, Savile-row, Burlington-gardens.

1857-58 Gowlland, Peter Y., Esq., Surgeon to St. Mark's Hospital, 34, Finsbury-square.

1846-47 Gream, George T., M.D., 2, Upper Brook-street, Grosvenor-square.

1856-57 Greenhalgh, Robert, M.D., Physician-Accoucheur to St. Bartholomew's Hospital, 76, Grosvenor-street.

‡1854-55 Greenhill, William Alexander, M.D., Carlisle-parade, Hastings.

1863-64 Greenhow, Edward Headlam, M.D., Assistant-Physician to the Middlesex Hospital, 77, Upper Berkeley-street.

1860-61 Gueneau de Mussy, Henri, M.D., 4, Cavendish-place, Regent-street.

1863-64 Gull, William Withey, M.D., Physician to Guy's Hospital, 26, Brook-street, Grosvenor-square.

1858-59 Gunn, Theophilus Miller, Esq., 40, York-place, Portman-square.

1851-52 Hacon, E. Dennis, Esq., Mare-street, Hackney.

†1851-52 Halley, Alexander, M.D., 7, Harley-street, Cavendish-square.

1851-52 Hansard, Richard James, Esq.

*1847-48 Hare, Charles John, M.D., Physician to University College Hospital, 41, Brook-street, Grosvenor-square.

†1855-56 Harley, George, M.D., F.R.S. (C.), Assistant-Physician to University College Hospital, 77, Harley-street.

1862-63 Harling, Robert Dawson, M.D. Lond., 9, Upper Seymour-street, Portman-square.

1859-60 Harris, Francis, M.D., Assistant-Physician to St. Bartholomew's Hospital, and to the Hospital for Sick Children, 24, Cavendish-square.

†1857-58 Hart, Ernest, Esq., Ophthalmic Surgeon to St. Mary's Hospital, 69, Wimpole-street.

†1859-60 Hastings, Cecil William, M.B., 14, Albemarle-street.

**Orig. Memb.* Hawkins, Cæsar H., Esq., F.R.S. (formerly President), Consulting-Surgeon to St. George's Hospital, 26, Grosvenor-street.

1856-57 Hawksley, Thomas, M.D., Physician to the Margaret-street Dispensary for Consumption, 70, Brook-street, Hanover-square.

Elected Session

1856-57 Heath, Christopher, Esq., Assistant-Surgeon to the Westminster Hospital, 9, Cavendish-place, Cavendish-square.

1861-62 Henderson, Joseph, Esq., Deptford.

**Orig. Memb.* Hewett, Prescott G., Esq. (V.P.) (late President), Surgeon to St. George's Hospital, 1, Chesterfield-street, May-fair.

1854-55 Hewitt, Graily, M.D. (C), Obstetric Physician to University College Hospital, 36, Berkeley-square.

1863-64 Hickman, William, M.B., 1 Dorset-square.

1863-64 Hicks, J. Wale, M.D., 16, Ridley-road, Dalston.

1859-60 Hill, Matthew Berkeley, M.B. Lond., Assistant-Surgeon to University College Hospital, 14, Weymouth-street, Portland-place.

1854-55 Hillier, Thomas, M.D., Physician to the Hospital for Sick Children, Medical Officer of Health for St. Pancras, 32, Queen Anne-street, Cavendish-square.

**Orig. Memb.* Hillman, William Augustus, Esq., Senior Assistant-Surgeon to the Westminster Hospital, 1, Argyll-street, Regent-street.

*†*Orig. Memb.* Hilton, John, Esq., F.R.S. (late V.P.), Surgeon to Guy's Hospital, 10, New Broad-street, City.

1855-56 Hinton, J., Esq., Aural Surgeon to Guy's Hospital, 5, George-street, Hanover-square.

*1850-51 Hodgson, Joseph, Esq., F.R.S., 60, Westbourne-terrace.

*1852-53 Hogg, Jabez, Esq., Assistant-Surgeon to the Westminster Ophthalmic Hospital, 1, Bedford-square.

1846-47 Holman, H. Martin, M.D., Hurstpierpoint, Sussex.

*1854-55 Holmes, Timothy, Esq. (Hon. Secretary), Surgeon-in-Chief to the Metropolitan Police, Assistant-Surgeon to St. George's Hospital, and Surgeon to the Hospital for Sick Children, 22, Queen-street, May-fair.

*1849-50 Holt, Barnard Wight, Esq., Senior-Surgeon to the Westminster Hospital, 14, Savile-row.

**Orig. Memb.* Holthouse, Carsden, Esq., Surgeon to, and Lecturer on Surgery at the Westminster-Hospital, 2, Storey's-gate, St. James's-park.

1863-64 Hood, Wharton P., M.D., 15, Lower Seymour-street, Portman-square.

1853-54 Hood, William Charles, M.D., Visiting Physician in Lunacy to the Court of Chancery, Croydon Lodge, Surrey.

1864-65 Hooper, John Harward, Esq., M.B., Tenby, South Wales.

1856-51 Hore, Henry A., Esq., Surgeon to the Bristol Royal Infirmary, 31, Park-street, Bristol.

1857-58 Hornidge, Thomas King, Esq., 15, Charles-street, Westbourne-terrace.

†1855-56 Hudson, John, M.D., 11, Cork-street.

1854-55 Hulke, John Whitaker, Esq. (C.), Assistant-Surgeon to the Middlesex Hospital, and to the Royal London Ophthalmic Hospital, 10, Old Burlington-street.

1854-55 Hulme, Edward Charles, Esq., Surgeon to the Great Northern Hospital, and to the Central London Ophthalmic Hospital, 38, Gower-street, Bedford-square.

Elected Session

1852-53 Humby, Edwin, Esq., 83, Hamilton-terrace, St. John's-wood.

*1852-53 Hutchinson, Jonathan, Esq., Surgeon to the London Hospital, and Assistant-Surgeon to the Royal London Ophthalmic Hospital, Moorfields, 4, Finsbury-circus.

†1860-61 Ingram, Charles, M.D., Physician to the Royal General Dispensary, Aldersgate.

‡1856-57 Jackson, Henry, Esq., Senior Surgeon to the Sheffield Infirmary, St. James's-row, Sheffield.

1859-60 Jackson, Thomas Carr, Esq., Surgeon to the Great Northern Hospital, 3, Weymouth-street, Portland-place.

‡1853-54 Jardine, John Lee, Esq., Capel, near Dorking, Surrey.

1846-47 Jay, Edward, Esq., 51, Park-street, Grosvenor-square.

**Orig. Memb.* Jeaffreson, Henry, M.D. (formerly V.P.), Physician to St. Bartholomew's Hospital, 8, Finsbury-square.

**Orig. Memb.* Jenner, William, M.D., F.R.S. (late V.P.), Physician to the University College Hospital, 8, Harley-street.

1861-62 Jephson, John Holmes, M.D., Physician to the Great Northern Hospital, 1, Conduit-street West, Hyde-park.

1854-55 Johnson, Athol A. W., Esq., 20, Regency-square, Brighton.

1854-55 Johnson, Edward, M.D., 19, Cavendish-place, Cavendish-square.

**Orig. Memb.* Johnson, George, M.D. (late V.P.), Physician to King's College Hospital, 11, Savile-row.

*†*Orig. Memb.* Jones, Henry Bence, M.D., F.R.S. (formerly V.P.), 31, Brook-street, Grosvenor-square.

1853-54 Jones, Sydney, M.B. (C.), Assistant-Surgeon to St. Thomas's Hospital, 15, St. Thomas's-street.

1861-62 Jones, Thomas, Esq., St. George's Hospital.

1858-59 Jones, William Price, M.D., Surbiton, Kingston.

1859-60 Jones, Walter, Esq., College-yard, Worcester.

1846-47 Kent, Thomas J., Esq., 60, St. James's-street.

1852-53 Kershaw, W. Wayland, M.D., Kingston-on-Thames.

1859-60 Kiallmark, Henry Walter, Esq., 46, Prince's-square, Bayswater.

1851-52 Kingdon, J. Abernethy, Esq., Surgeon to the City Dispensary, and to the City of London Truss Society, 2, New Bank-buildings.

‡1856-57 Kingsley, Henry, M.D., Physician to the Stratford Infirmary, Stratford-on-Avon, Warwickshire.

1854-55 Kirby, Edmund A., M.D., 26, Gordon-square.

*1850-51 Langmore, John C., M.B., 48, Sussex-gardens, Hyde-park.

1857-58 Lankester, Edwin, M.D., F.R.S., Medical Officer of Health for St. James's, Westminster, 8, Savile-row.

*1849-50 Latham, Peter Mere, M.D. (formerly President), late Physician to St. Bartholomew's Hospital, 36, Grosvenor-street.

Elected Session

1856-57 Laurence, John Z., Esq., Surgeon to the St. Marylebone General Dispensary, 30, Devonshire-street, Portland-place.

1853-54 Lawrence, Henry John Hughes, Esq., Assistant-Surgeon Grenadier Guards' Hospital, Rochester-row, Westminster.

1858-59 Lawson, George, Esq., Assistant-Surgeon to the Middlesex Hospital, and to the Royal London Ophthalmic Hospital, Moorfields, 5, Harley-street, Cavendish-square.

1864-65 Leach, Harry, Esq., H.M.S. "Dreadnought."

1857-58 Leared, Arthur, M.B., Physician to the Royal Infirmary for Diseases of the Chest, 12, Old Burlington-street.

*1851-52 Lee, Henry, Esq., Surgeon to St. George's Hospital, 9, Savile-row.

1852-53 Leggat, Alfred, Esq., 13, William-street, Lowndes-square.

1864-65 Leighton, Edmund Thomas, M.B., 4, Henrietta-street, Cavendish-square.

1861-62 Lichtenberg, George, M.D., 10, Finsbury-place.

1848-49 Little, William John, M.D. (formerly V.P.), 34, Brook-street, Grosvenor-square.

†1862-63 Little, Louis S., Esq., Assistant-Surgeon to the London Hospital, 2, West-street, Finsbury.

1863-64 Liveing, Robert, M.B., Demonstrator of Anatomy at the Middlesex Hospital, 78, Grosvenor-street.

‡1860-61 Lund, George, M.D., 3, Park-villas East, Richmond, Surrey.

1858-59 Mackay, Allan Douglas, M.B., Stony-Stratford, Bucks.

1863-64 Mackenzie, Morell, M.D., 13, Weymouth-street, Portland-place.

1857-58 Marcet, William, M.D., F.R.S., 1, Torrington-street, Torrington-square.

*1851-52 Markham, William O., M.D., Physician to St. Mary's Hospital, 3, Harley-street, Cavendish-square.

*1846-47 Marshall, John, Esq., F.R.S., Surgeon to University College Hospital, 10, Savile-row.

‡1860-61 Martin, John, Esq., Cambridge House, Portsmouth, and Keydell, near Horndean, Hants.

1856-57 Martin, Robert, M.D., Assistant-Physician to St. Bartholomew's Hospital, 19, Queen Anne-street.

1852-53 Martyn, S., M.D., Senior Physician to the Bristol General Hospital, 26, Park-street, Bristol.

1858-59 Martyn, William, M.D., 6, Trevor-terrace, Rutland-gate, Brompton.

1860-61 Mason, Francis, Esq., 10, Conduit-street, Regent-street.

†1858-59 Maunder, C. F., Esq., Assistant-Surgeon to the London Hospital, 29, New Broad-street.

‡1851-52 May, George, Jun., M.B., Surgeon to the Royal Berkshire Hospital, Reading.

1857-58 Meller, Charles James, Esq.

1859-60 Messer, John Cockburn, M.D., Assistant-Surgeon, R.N., Her Majesty's ship, "Edinburgh," Queensferry, N.B.

†1858-59 Montefiore, Nathaniel, Esq., 36, Hyde-park-gardens.

1860-61 Montgomery, Edmund, M.D., St. Thomas's Hospital.

1861-62 Morehead, Charles, M.D.

Elected Session

*1846-47 Morgan, John, Esq., 3, Sussex-place, Hyde-park-gardens.

1852-53 Moseley, George, Esq., 23, Priory-road, Kilburn.

1859-60 Moxon, Walter, M.B., Demonstrator of Anatomy at Guy's Hospital, 6, Finsbury-circus.

*1854-55 Murchison, Charles, M.D. (Hon. Sec.), Assistant-Physician to the Middlesex Hospital, and Senior Physician to the London Fever Hospital, 79, Wimpole-street.

Mussy, *see* Gueneau de Mussy.

1864-65 Myers, Arthur, B. R., Esq., Coldstream Guards Hospital, Vincent-square, Westminster.

1864-65 Newman, William, M.D., Stamford, Lincolnshire.

1863-64 Norton, A. T., Esq., 4, Westbourne-grove West.

1864-65 Noverre, Arthur, Esq., 25, South-street, Park-lane.

1856-57 Nunn, Thomas William, Esq. (C.), Surgeon to the Middlesex Hospital, 8, Stratford-place, Oxford-street.

‡1858-59 Nunneley, Thomas, Esq., Senior Surgeon to the Leeds Eye and Ear Infirmary, Leeds.

*1850-51 Obré, Henry, Esq., Surgeon to the St. Marylebone Eye and Ear Institution, 1, Melcombe-place, Dorset-square.

*1850-51 Ogle, John W., M.D. (V.P.) (late Honorary Secretary), Assistant-Physician to St. George's Hospital, 13, Upper Brook-street, Grosvenor-square.

‡1855-56 Oldfield, Edmund, Esq., Boscomb Lodge, Finchley-road.

1859-60 Orange, William, Esq., Broadmoor, Berkshire.

1857-58 Ord, William Miller, M.B., Lecturer on Comparative Anatomy at St. Thomas's Hospital, Brixton-hill.

1863-64 Orme, E., Esq., Curator of the Museum, University College Hospital.

1864-65 Owles, James Allden, M.D., House-Surgeon, Hospital for Women, Soho-square.

‡1859-60 Paget, Edward H., Esq., Friar-lane, Leicester.

1863-64 Palfrey, James, M.D., Assistant-Obstetric Physician to the London Hospital, 25, Finsbury-place.

1853-54 Parkinson, George, Esq., 16, Lower Brook-street, Grosvenor-square.

1853-54 Part, James, M.D., 7, Camden-road-villas, Camden-town.

**Orig. Memb.* Partridge, Richard, Esq. F.R.S., (formerly V.P.), Surgeon to King's College Hospital, 17, New-street, Spring-gardens.

**Orig. Memb.* Peacock, Thomas Bevill, M.D. (President), Physician to St. Thomas's Hospital, and Physician to the City of London Hospital for Diseases of the Chest, 20, Finsbury-circus.

1862-63 Pearson, David R., M.D., 23, Upper Phillimore-place, Kensington.

1863-64 Pick, Thomas, Esq., Surgical Registrar to St. George's Hospital, 9, Bolton-row.

1863-64 Playfair, W. S., M.D., Assistant-Physician for the Diseases of Women and Children, King's College, Hospital, 5, Curzon-street, May-fair.

1860-61 Pocock, William, Esq., 1, St. John's-villas, Brixton-road.

Elected Session

*1846-47 Pollock, George D., Esq. (V.P.) (late Hon. Sec.), Surgeon to St. George's Hospital, 27, Grosvenor-street.

*1850-51 Pollock, James Edward, M.D. Physician to the Hospital for Consumption and Diseases of the Chest, Brompton, 52, Upper Brook-street.

1861-62 Pollock, Arthur Julius, M.D., 21, Montague-place, Russell-square.

1858-59 Potter, Henry, Esq., 56, Maddox-street, Hanover-square.

1854-55 Potts, William, Esq., 12, North Audley-street, Grosvenor-square.

1856-57 Priestley, William Overend, M.D., Physician for the Diseases of Women and Children to King's College Hospital, Consulting Physician-Accoucheur to the St. Marylebone Infirmary, 17, Hertford-street, May-fair.

*†1848-49 Purnell, John James, Esq., Surgeon to the Royal General Dispensary, Woodlands, Streatham-hill.

*1850-51 Pyle, John, Esq., 59, Oxford-terrace, Hyde-park.

**Orig. Memb.* Quain, Richard, M.D. (Treasurer, formerly Hon. Secretary), Physician to the Hospital for Consumption and Diseases of the Chest, Brompton, 56, Harley-street, Cavendish-square.

1859-60 Radcliffe, Charles Bland, M.D., Physician to the Westminster Hospital, 25, Cavendish-square.

1855-56 Rae, James, Esq., Surgeon, R.N., Haslar Hospital.

**Orig. Memb.* Ramsbotham, Francis H., M.D.

1856-57 Ramskill, J. Spence, M.D., Physician to the National Hospital for the Paralysed and Epileptic, 5, St. Helen's-place, Bishopsgate-street.

1847-48 Randall, John, M.D. (C.), Medical Officer, St. Marylebone Infirmary, 14, Portman-street, Portman-square.

1856-57 Ranke, Henry, M.D., Munich.

1864-65 Rasch, Adolphus, M.D., 7, South-street, Finsbury-square.

1846-47 Ray, Edward, Esq. (C.), Dulwich.

1858-59 Reed, Frederick George, M.D., 46, Hertford-street, May-fair.

1854-55 Reynolds, J. Russell, M.D., Physician to University College Hospital, 38, Grosvenor-street.

**Orig. Memb.* Ridge, Joseph, M.D., 39, Dorset-square.

1863-64 Roberts, Arthur, Esq., 37, Kensington-square.

1855-56 Roberts, John Henry, Esq., 10, Finchley-road, St. John's-wood.

1863-64 Robinson, Charles, Esq., 11, Montagu-street, Montagu-square.

1856-57 Robinson, Thomas, M.D., 64, Lamb's Conduit-street.

1859-60 Robinson, Frederick, M.D., Battalion Surgeon, Scots Fusileer Guards' Hospital, 48, Charlwood-street, Belgrave-road.

Orig. Memb. Roe, George Hamilton, M.D., Senior-Physician to the Hospital for Consumption and Diseases of the Chest, Brompton, 57, Park-street, Grosvenor-square.

1858-59 Rolleston, George, M.D., F.R.S., 5, Broad-street, Oxford.

1851-52 Rooke, H. T., M.D., Surgeon to the Seamen's Hospital-ship, "Dreadnought."

Elected Session

1858-59 Rose, Henry Cooper, M.D., Hampstead.

1858-59 Rouse, James, Esq., Assistant-Surgeon to the Royal Ophthalmic Hospital, 2, Wilton-street, Grosvenor-place.

*1852-53 Salter, Henry Hyde, M.D., F.R.S., Assistant-Physician to the Charing Cross Hospital, 6, Montague-street, Russell-square.

*1853-54 Salter, Samuel James A., M.B., F.R.S., Surgeon-Dentist to Guy's Hospital, 17, New Broad-street, City.

1852-53 Sanderson, Hugh James, M.D., Physician to the Hospital for Women, 26, Upper Berkley-street.

1854-55 Sanderson, John Burdon, M.D. (C.), Assistant-Physician to the Middlesex Hospital, Medical Officer of Health for Paddington, 49, Queen Anne-street, Cavendish-square.

1857-58 Schulhof, Maurice, M.D., Physician to the Royal General Dispensary, Bartholomew-close, 14, Brook-street.

1853-54 Scott, John, Esq., Surgeon to the Hospital for Women, Soho-square, 65, Harley-street, Cavendish-square.

‡1858-59 Scratchley, George, M.D., B.L.S., Member of the University of France, New Orleans, Louisiana, U.S.

*‡1846-47 Seaton, Edward, C., M.D., Rochester-house, Surbiton.

1856-57 Sedgwick, William, Esq., Surgeon to the Marylebone Provident Dispensary, 12, Park-place, Upper Baker-street.

*1852-53 Semple, Robert Hunter, M.D., Physician to the Northern Dispensary, 8, Torrington-square.

**Orig. Memb.* Shaw, Alexander, Esq. (late V.P), Surgeon to the Middlesex Hospital, 25, Henrietta-street, Cavendish-square.

1856-57 Shillitoe, Buxton, Esq., Surgeon to the Great Northern Hospital, and to the Islington Dispensary, 34, Finsbury-circus.

1855-56 Sibley, Septimus W., Esq., 12, New Burlington-street.

*1848-49 Sibson, Francis, M.D., F.R.S., Physician to St. Mary's Hospital, 40, Brook-street, Grosvenor-square.

*1847-48 Sieveking, Edward H., M.D. (V.P.), Physician to St. Mary's Hospital, 17, Manchester-square.

**Orig. Memb.* Simon, John, Esq., F.R.S. (formerly V.P.), Surgeon to St. Thomas's Hospital, 8, Richmond-terrace, Whitehall.

1864-65 Sims, J. Marion, M.D., 1, Bolton-row, May-fair.

**Orig. Memb.* Smith, Ebenezer Pye, Esq., 7, Billiter-square, and Mare-street, Hackney.

1863-64 Smith, Henry, Esq., Assistant-Surgeon to King's College Hospital, 16, Caroline-street, Bedford-square.

1864-65 Smith, Peter, M.D., 29, Wimpole-street, Cavendish-square.

1846-47 Smith, Protheroe, M.D., Physician to the Hospital for Women, 25, Park-street, Grosvenor-square.

1851-52 Smith, W. Tyler, M.D., Physician-Accoucheur to St. Mary's Hospital, 21, Upper Grosvenor-street.

Elected Session

1855-56 Smith, Spencer, Esq., Surgeon to St. Mary's Hospital, 9, Queen Anne-street, Cavendish-square.

1856-57 Smith, Thomas, Esq., Assistant-Surgeon to St. Bartholomew's Hospital, 7, Montague-street, Russell-square.

*1847-48 Solly, Samuel, Esq., F.R.S., Surgeon to St. Thomas's Hospital, 6, Savile-row.

1854-55 Squire, William, Esq., 6, Orchard-street, Portman-square.

1860-61 Squire, Alexander Balmanno, Esq., 12, York-gate, Regent's-park.

1854-55 Stewart, William Edward, Esq., Surgeon to St. Marylebone Provident Dispensary, 12, Weymouth-street, Portland-place.

1862-63 Stone, William Domett, M.D., 42, Lincoln's-inn-fields.

1862-63 Stone, William Henry, M.D., Oxon, 13, Vigo-street, Regent-street.

†1853-54 Streatfeild, J. F., Esq., Assistant Surgeon to the Royal London Ophthalmic Hospital, Moorfields, and to the Eye Infirmary in University College Hospital, 15, Upper Brook-street.

1862-63 Sturges, Octavius, M.B. Cant., 85, Wimpole-street.

†1850-51 Sutherland, Alex. John, M.D., F.R.S., 6, Richmond-terrace, Whitehall.

1863-64 Sutton, Henry G., M.B., 25, Montague-place, Russell-square.

1858-59 Swete, Benjamin L., Esq., Surgeon to the British Orphan Asylum, Clapham-rise, 7, Park-road, Stockwell.

‡1856-57 Symonds, Frederick, Esq., Surgeon to the Radcliffe Infirmary, 32, Beaumont-street, Oxford.

Orig. Memb. Tamplin, R. W., Esq., Surgeon to the Royal Orthopædic Hospital, 33, Old Burlington-street.

‡1855-56 Tapp, W. Denning, Esq., 41, Argyll-road, Kensington.

1863-64 Tatham, John, M.D., 1, Wilton-place, Knightsbridge.

1851-52 Taylor, Robert, Esq., Surgeon to the Central London Ophthalmic Hospital, 21, Edwards-street, Portman-square.

1860-61 Teevan, William Frederic, Esq., Surgeon to the West London Hospital, 10, Portman-square.

*1852-53 Thompson, Henry, Esq. (late Honorary Secretary) (C.), Surgeon to University College Hospital, 35, Wimpole-street, Cavendish-square.

‡1861-62 Thompson, Joseph, Esq., Surgeon to the Nottingham General Hospital, Oxford-street, Nottingham.

1856-57 Tomes, J., Esq., F.R.S., Surgeon-Dentist to the Middlesex Hospital, 37, Cavendish-square.

1864-65 Tonge, Morris, M.D., Medical Registrar, King's College Hospital, 5, Bolton-row, May-fair.

**Orig. Memb.* Toynbee, Joseph, Esq., F.R.S. (V.P.), Aural Surgeon to St. Mary's Hospital, 18, Savile-row.

1851-52 Trotter, John W., Esq. (C.), Assistant-Surgeon, Coldstream Guards' Hospital, Vincent-square, Westminster.

1859-60 Truman, Edwin Thomas, Esq., Surgeon-Dentist in Ordinary to Her Majesty's Household, 23, Old Burlington-street.

1857-58 Tudor, John, Esq.

Elected Session

1852-53 Tulloch, James S., M.D., 1, Pembridge-place, Bayswater.
1863-64 Turner, James Smith, Esq., 30, Margaret-street, Cavendish-square.
1857-58 Turtle, Frederick, Esq., Lamberhurst, Surrey.

1854-55 Vasey, Charles, Esq., Surgeon-Dentist to St. George's Hospital, 5, Cavendish-place, Cavendish-square.

Orig. Memb. Waite, Charles D., M.D., Senior Physician to the Westminster General Dispensary, 3, Old Burlington-street.
1864-65 Walker, Joseph, M.D., 82, Wimpole-street.
1859-60 Walters, John, M.B. Lond., Assistant-Surgeon attached to Second Battalion, 17th Regiment.
‡*Orig. Memb.* Ward, Joseph, Esq., Epsom, Surrey.
*1846-47 Ward, T. Ogier, M.D., Cowbridge, Glamorganshire.
1857-58 Wardell, John Richard, M.D., 4, Belmont, Tunbridge Wells.
*1855-56 Watson, Thomas, M.D., F.R.S. (late President), Consulting-Physician to King's College Hospital, 16, Henrietta-street, Cavendish-square.
1864-65 Watson, W. Spencer, Esq., Assistant-Surgeon to King's College Hospital, 27, Montague-street, Russell-square.
1860-61 Way, John, M.D., 13, St. George's-road, Eccleston-square.
1857-58 Weber, Hermann, M.D., Physician to the German Hospital, 49, Finsbury-square.
1864-65 Welch, Thomas Davies, Esq., M.B., Lee, Kent.
1860-61 Wells, John Soelberg, Esq., Ophthalmic Surgeon to King's College Hospital, 16, Savile-row.
1853-54 Wells, Thomas Spencer, Esq. (C.), Surgeon to the Samaritan Free Hospital for Women and Children, 3, Upper Grosvenor-street.
*1850-51 West, Charles, M.D., Physician to the Hospital for Sick Children, 61, Wimpole-street, Cavendish-square.
1858-59 White, Frederick, Esq., 20, Oxford-terrace, Hyde-park.
1863-64 Wilks, Alfred G. P., M.A., M.B., Guy's Hospital.
*1854-55 Wilks, Samuel, M.D., Assistant-Physician to Guy's Hospital, 11, St. Thomas's-street, Southwark.
**Orig. Memb.* Williams, C. J. B., M.D., F.R.S. (formerly President, late V.P.), Consulting-Physician to the Hospital for Consumption and Diseases of the Chest, Brompton, 49, Upper Brook-street, Grosvenor-square.
‡1858-59 Williams, Charles, Esq., Surgeon to the Norwich Dispensary, Norwich.
1863-64 Williams, W. Rhys, Esq., Bethlehem Hospital.
1859-60 Williamson, George, M.D., Fort Pitt, Chatham.
1863-64 Willis, Francis, Esq., M.B., Oxon, 45, Upper Brook-street.
1858-59 Wilson, Edward Thomas, M.B., Montpelier-terrace, Cheltenham.
1859-60 Wilson, Robert James, Esq., 24, Grand Parade, St. Leonard's-on-Sea.
1863-64 Wiltshire, Alfred, M.D., 100, Hampstead-road.
‡1861-62 Windsor, Thomas, Esq., Surgeon to the Salford Royal Hospital, 65, Piccadilly, Manchester.
1864-65 Witherby, William H., M.D., Coombe, Croydon.

Elected Session

*1850-51 Wood, John, Esq., Assistant-Surgeon to King's College Hospital, 4, Montague-street, Russell-square.

1854-55 Wood, William, M.D., Physician to St. Luke's Hospital, 54, Upper Harley-street.

1863-64 Worley, William Charles, Esq., 1, New North Road, Hoxton.

1859-60 Wotton, William Gordon, Esq., King's Langley, Herts.

1852-53 Wright, Edward John, Esq., 13, Montague-place, Clapham-road.

LIST OF SPECIMENS

EXHIBITED AT THE MEETINGS OF THE SOCIETY DURING THE SESSION, 1864-5.

DISEASES, ETC., OF THE NERVOUS SYSTEM.

		Page
1. Obstruction by clot of right middle cerebral artery in a patient who had been suffering from secondary syphilis, and who was free from heart disease.	Dr. Bristowe . .	1
2. Ulceration of the inner surface of the cranium in connection with a carcinomatous growth of the brain from a case of mania and hemiplegia.	Dr. John W. Ogle .	4
3. Atrophy of the left cerebral hemisphere with atrophy of the arm of the opposite side of the body, from a confirmed epileptic who died of phthisis.	Dr. John W. Ogle .	5
4. Cyst in the cavity of the arachnoid.	Dr. Samuel Wilks .	6
5. Three examples of encephalocele of the anterior part of the skull.	Mr. Christopher Heath	8

		Page
6. Encephalocele of the posterior part of the skull.	Mr. Christopher Heath for Mr. Henry Power	12
7. Case of spina bifida in progress of spontaneous cure.	Dr. W. G. Playfair	13
8. Disease of the brain of a tubercular nature associated with loss of the use of language	Mr. Jonathan Hutchinson	14
9. Right hemiplegia, with complete loss of speech; partial improvement. Attacks of epileptiform convulsion. Increase of paralysis. Death. Brain healthy. Granular degeneration of spinal cord.	Dr. Morris Tonge	16
10. Extensive hæmorrhage into the right hemisphere of the brain, from a patient who died in epileptiform convulsions.	Mr. Jabez Hogg	17
11. Atrophy of the brain from an idiot.	Dr. Murchison	20
12. Disease of the temporal bone, and abscess of the cerebellum.	Mr. A. T. Norton	20
13. Tumour pressing on the spinal cord.	Dr. William Cayley	21
14. Gliomatous tumour of the brain.	Dr. William Cayley	23

		Page
15. Softening of the entire spinal cord, from a case of general paralysis of the insane, associated with epilepsy	Dr. John W. Ogle	25
16. General paralysis of the insane. Epileptic attacks. Softening of the spinal cord. Brain unusually firm.	Dr. John W. Ogle	25
17. General paralysis and dementia. Softening of the brain-substance and of the spinal cord. Pus in the theca vertebralis.	Dr. John W. Ogle	26
18. Thrombosis of cerebral sinuses, with apoplexy of optic thalami, consequent on anæmia.	Dr. Andrew	27
19. Cerebro-spinal meningitis.	Dr. Andrew	
20. Cases of cerebro-spinal meningitis observed in the epidemic of Dantzig.	Dr. J. Burdon Sanderson	30
21. On paraplegia after fever.	Mr. J. Lockhart Clark	33
22. Paraplegia, commencing with symptoms thought to be those of sciatica. Caries of the lumbar vertebræ. Effused fibrin external to the spinal dura mater. Corresponding pressure upon, and slight softening of, the spinal cord.	Dr. John W. Ogle	34

Page

23.
Encephalocele of the posterior part of the skull. — Dr. Murchison for Dr. Henry G. Wright — 35

DISEASES, ETC., OF THE ORGANS OF RESPIRATION.

1.
Necrosis of the cricoid cartilage, with incipient ossification, in the case of a man, æt. 30. — Dr. Morell Mackenzie. — 37

2.
Congenital aphonia. Excrescences in the larynx. Deceptive sensation on introduction of the finger into the larynx during life. — Dr. Morell Mackenzie. — 37

3.
Two cases of laryngeal excrescence in very young children, in which the growths were removed by forceps, with the aid of the laryngoscope. — Dr. Morell Mackenzie. — 38

4.
A case of cirrhosis of the lung. — Dr. G. Hilaro Barlow . — 39

Report on the above specimen. — Dr. H. G. Sutton . . — 42

5.
Chronic ulceration of the larynx. — Mr. William Squire for Mr. W. D. Spanton . — 44

6.
Patient recovered from necrosis of the cricoid cartilage. — Dr. Gibb . . . — 45

7.
Portions of ossified tracheal rings expelled some months after tracheotomy. — Dr. Gibb . . . — 46

		Page
8. Case of diphtheria, with pulmonary apoplexy and intense congestion of the stomach and ileum.	Dr. Greenhow	46
9. Case of bronchial casts.	Dr. Hilton Fagge	48
10. Primary cancer of the left lung and of the mediastinal glands.	Dr. Andrew	51
11. Disease of the trachea, probably syphilitic, opening into the aorta.	Dr. Samuel Wilks	52
12. Primary epithelial cancer of the epiglottis and pharynx, involving the vocal cords.	Mr. A. T. Norton	53
13. Primary cancer of the larynx, destroying the epiglottis, as seen with the laryngoscope.	Dr. Gibb	54
14. Cornish miner's lungs.	Dr. Peacock	57
15. Specimen of diseased lung from a case of grinder's asthma.	Dr. Greenhow	59
16. Specimen of coal-miner's black lung.	Dr. Greenhow	60
17. Diphtheritic membrane from the trachea.	Dr. Semple	61

DISEASES, ETC., OF THE ORGANS OF CIRCULATION.

		Page
1. Case of opening in septum ventriculorum. Pulmonary artery and aorta given off from the heart as one trunk.	Mr. Christopher Heath for Mr. Henry Power	62
2. Dissecting aneurism of the abdominal aorta.	Dr. Greenhow . .	63
3. Fleshy column of diseased mitral valve ruptured during violent vomiting.	Dr. Peacock . . .	67
4. Dilatation of right side of heart, associated with extremely dense deposit of tubercle in lungs.	Dr. Frederick Robinson	69
5. A case of plugging of the right and left branches of the pulmonary artery in rheumatic fever; rapid death.	Dr. Wm. Martyn . .	71
6. Case of rupture of one of the musculi papillares of the tricuspid valves.	Mr. William Squire for Mr. W. D. Spanton .	73
7. Entire loss of two of the pulmonary valves.	Dr. Samuel Wilks .	74
8. Case of aneurism of the aorta pressing upon the pulmonary artery.	Dr. Julius Pollock .	76

		Page
9. Rupture of one of the aortic valves.	Dr. Samuel Wilks	77
10. Rupture of aorta from injury.	Dr. Samuel Wilks	79
11. Malformation of the septum ventriculorum from a patient who died of diphtheria.	Dr. Hare	80
12. Congenital malformation of pulmonary valves.	Dr. Andrew	81
13. Ruptured chordæ tendineæ of the mitral valve.	Dr. Julius Pollock	82
14. Aneurism of the basilar artery. Rupture and effusion of blood into the sheath of the spinal cord.	Dr. Henry William Fuller	83
15. Extensive disease of aorta in a young man. Sudden death.	Mr. John S. Gabriel, R.N.	85
16. Rupture of the left internal carotid artery.	Dr. William Cayley	85
17. Coagulum in the pulmonary artery, occurring after a natural labour.	Dr. Morris Tonge	87
18. Case of bony deposit in the mitral valve, with contraction of the orifice, associated with congenital malformation.	Dr. Frederick Robinson	89

		Page
19. Heart with open foramen ovale without cyanosis. Thickening of the pulmonary valves.	Dr. J. Wale Hicks	91
20. Aneurism of mitral valve.	Dr. Andrew	91
21. Obliteration of the inferior vena cava.	Dr. Andrew	92
22. Embolism of the iliac, femoral, and other arteries, and thrombosis of the femoral and popliteal veins, from a case of typhus fever, complicated with œdema and gangrene of the lower extremities.	Dr. Murchison	93
23. Aneurism of the aorta, with rupture into the right ventricle of the heart.	Dr. Lichtenberg	96
24. Aneurism of the aorta.	Dr. Julius Pollock	98
25. Cases of cancerous deposit in the heart.	Dr. Peacock	99
26. Ulcerated cavity in the wall of the heart. Death from meningitis.	Dr. Murchison	121
27. Case of ruptured aneurism of the heart.	Dr. Bagshawe	122
28. Thoracic aneurism, involving the arteria innominata and arch of the aorta.	Mr. Harry Leach	123

DISEASES, ETC., OF THE ORGANS OF DIGESTION.

A.—STOMACH AND INTESTINES.

		Page
1. Intestines from a case of typhus fever complicated with diarrhœa.	Dr. Murchison	124
2. Intestines of a child who died of enteric fever at the age of 6 months.	Dr. Murchison	125
3. Poisoning by butter of antimony (chloride of antimony).	Dr. Crisp	125
4. Strangulation of intestine by diverticulum ilei.	Dr. Samuel Wilks	126
5. Large intestine from a case of typhoid fever.	Dr. Samuel Wilks	127
6. Traumatic abdominal hernia, with extensive rupture of the recti abdominis muscles, involving the left epigastric artery.	Mr. Gay	128
7. Colloid cancer of peritoneum.	Mr. Francis Mason	128
8. The stomach, duodenum, and part of the jejunum of a very fat man weighing about eighteen stones.	Dr. Crisp	130
9. Post-mortem bursting of the stomach.	Dr. Dickinson	130

		Page
10. Two cases of enteritis.	Dr. Dickinson	132
11. Herniotomy for the second time—fatal. Thickening of the gut by the pressure of an ill-fitting truss on an irreducible hernia.	Mr. Holmes	135
12. Large chronic ulcer of stomach. Perforation of splenic artery. Short duration of stomach symptoms.	Dr. Hare	137
13. Colloid cyst in the wall of the cæcum.	Dr. Dickinson	138
14. Case of meso-colic hernia.	Mr. E. R. Bickersteth	139
15. Case of extensive invagination of intestine.	Dr. W. S. Playfair	141
16. Ulcer of the transverse colon, communicating with the stomach.	Dr. J. Risdon Bennett	142
17. Intestines of a patient who died of a relapse of enteric fever.	Dr. Murchison	144
18. Case of sloughing of a piece of intestine.	Dr. Dickinson for Dr. MacLaurin, R.N.	145
19. Cancerous stricture of the rectum, from a patient in whom an anus was established in the left loin for the relief of symptoms.	Mr. T. B. Curling	146

B.—LIVER, ETC.

		Page
20. Amyloid disease of liver.	Dr. Cayley . . .	147
21. Series of gall-stones.	Dr. George Harley .	148
22. Hydatid tumour of the liver threatening to burst. Paracentesis. Recovery.	Dr. Murchison . .	148
23. Case of meningitis with atrophy of the liver, supervening on jaundice.	Dr. F. Robinson . .	152
Report on the above specimen.	Dr. G. Harley, Dr. Murchison . .	154
24. Hydatid tumour of the liver opening into the lung.	Dr. Julius Pollock .	154
25. Enormous accumulation of hydatids in the liver, producing great abdominal distension.	Dr. Gibb for Dr. Logan .	157
26. Large gall-stone passed per anum.	Dr. Leared . . .	159
27. Case of gall-stones.	Dr. Leared . . .	160
28. Case of hydatid tumour of the liver bursting into the bile-duct.	Dr. Murchison . .	160

DISEASES, ETC., OF THE GENITO-URINARY ORGANS.

A.—KIDNEYS, BLADDER, ETC.

		Page
1. Dilated kidneys in a child. Congenital hydro-nephrosis.	Dr. W. H. Broadbent	164
Report on the above specimen.	Dr. G. Harley, Dr. W. H. Broadbent	165
2. Atrophy of kidney and supra-renal capsule.	Dr. W. H. Broadbent	166
3. Kidneys with so-called fibrinous deposits, from embolism of the renal arteries, connected with mitral disease.	Dr. Hermann Weber	166
4. The urine of intermittent hæmaturia.	Dr. George Harley	168
5. Case of malformation of the bladder.	Mr. Holmes	169
6. Medullary tumour of the kidney.	Mr. T. Smith	171
7. Case of calculus adhering to the mucous lining of the bladder.	Mr. Thompson	172
8. Hair-pin removed by the high operation from a girl's bladder.	Mr. Henry Thompson	174
9. Intermittent hæmaturia.	Dr. Dickinson	174
10. Psoas abscess depending upon tubercular abscess in the kidney.	Dr. Dickinson	175

Page

11.
Pink lithate deposit. — Dr. Leared . . . 176

12.
Suppression of urine for ten days. The left kidney destroyed, and its ureter impervious; right ureter plugged up at its extremity. — Dr. Bagshawe . . 176

13.
Calculus from urinary bladder removed by lithotomy, having a blood-clot nucleus. — Mr. Nunn . . . 179

14.
Tuberculous disease of the kidney. — Dr. Thomas Ballard . 180

15.
Case of wasted kidney, from malformation of ureter. — Dr. Julius Pollock . 181

16.
Numerous spherical calculi passed by the urethra. — Mr. Nunn . . . 181

17.
Urine containing a large quantity of colouring matter resembling indigo. — Dr. Dickinson . . 181

18.
Intermittent hæmaturia. — Dr. Murchison . . 183

B.— MALE GENITAL ORGANS.

19.
Fibrous tumour of the scrotum, involving the left testicle. — Mr. Christopher Heath 183

20.
Case of milky fluid from the tunica vaginalis. Galactocele. — Mr. W. Fergusson . 184

		Page
Report on the above specimen.	Dr. George Harley, Mr. Francis Mason	184
21.		
Diseased prostate gland.	Mr. Francis Mason	187
Report on the above specimen.	Dr. Murchison, Mr. Henry Thompson	188
Appendix.	Dr. Murchison, Mr. Henry Thompson, Mr. Francis Mason	189
22.		
Congenital syphilitic disease of the testes.	Dr. S. Wilks	189
23.		
Malformation of penis.	Mr. Gay	189
24.		
Malignant disease of prostate.	Dr. Dickinson	190
25.		
Transverse hermaphroditism.	Mr. Partridge	191
26.		
Gangrene of the entire penis, occurring with typhus fever.	Mr. Partridge	192
27.		
The stump of a penis, after amputation, showing the good effects of slitting up the urethra in preventing subsequent contraction of its orifice.	Mr. Partridge	192
28.		
Epispadias.	Mr. Partridge	193

C.—FEMALE GENITAL ORGANS.

		Page
29. Ovariotomy, fatal by diffuse peritonitis.	Mr. Holmes . . .	195
30. Cancer of the ovaries, producing fatal obstruction of the bowels. Cancerous nodules of the peritoneum	Mr. Christopher Heath	196
31. Case of tubular fœtation.	Dr. W. S. Playfair .	197
32. Malignant disease of uterus, involving the whole of its internal surface, except the inferior portion of the canal of the cervix. Secondary deposits in both lungs.	Dr. J. Andrew . .	198
33. Large ovarian cyst closely adherent to the uterus, in which were developed three large fibrous tumours.	Dr. Hare . . .	199
34. Rupture of uterus in an early period of pregnancy.	Dr. Dickinson . .	203
35. Semi-solid ovarian tumour.	Mr. Spencer Wells .	206
36. Ovarian tumour successfully removed.	Mr. Holmes . . .	207
37. A specimen of an inverted uterus which during life had been successfully removed by ligature.	Dr. Ogle . . .	208

Page

Report on the above specimen. — Dr. John W. Ogle, Dr. J. Marion Sims, Dr. Graily Hewitt . 211

DISEASES, ETC., OF THE OSSEOUS SYSTEM.

1. Necrosis of turbinated bones and part of the vomer treated by aid of the rhinoscope. — Dr. Gibb . . . 212

2. Two cases of depressed fractures of the skull, for which no operations had been performed. — Mr. W. F. Teevan . . 213

3. Fracture of skull, with discharge from the meatus auditorius externus. — Mr. Gay . . . 213

4. Case of excision of the head of the right humerus and glenoid cavity of the scapula fifty years before death. — Mr. Fergusson . . 216

5. Elbow-joint, three years after successful excision. — Mr. Henry Smith . . 217

6. Sections of skulls showing the incorrectness of applying to the inner table of the skull the expression, "Lamina, vel tabula, vitrea." — Mr. W. F. Teevan . 217

7. Fibrous tumour from near the angle of the lower jaw. — Mr. Buxton Shillitoe . 223

		Page
8. Skull-cap showing congenital deficiencies of bone.	Mr. Thomas Smith .	224
9. Case of osteo-myelitis, or inflammation of the internal periosteum of the tibia.	Mr. Henry Lee .	225
10. Case of fibroid growth in the tibia.	Mr. E. R. Bickersteth	227
Report on the above specimen.	Mr. J. W. Hulke .	229

DISEASES, ETC., OF THE ORGANS OF SPECIAL SENSE.

1. Two cases of black cataract.	Mr. Thomas Windsor	230
Report on the above specimens.	Mr. J. W. Hulke .	233
2. Sebaceous tumours in the tympanum.	Mr. Hinton .	233
Report on the above specimen.	Mr. Joseph Toynbee, Mr. Thomas Smith, Mr. James Hinton	234
3. Melanotic tumour of the orbit.	Mr. J. Z. Laurence	235
4. Small tumour within the tympanum. Cicatrix (?) of the membrana tympani.	Mr. Hinton .	236

TUMOURS.

		Page
1. Fibro-fatty tumour of the neck, in a child, successfully removed.	Mr. Holmes	236
2. Fleshy tumour of the thigh.	Mr. Brooke	237
3. Medullary tumours of the leg, from an infant 17 months old.	Mr. Thomas Smith	238
4. Lobulated mammary tumour.	Mr. Gay	240

DISEASES, ETC., OF THE DUCTLESS GLANDS.

A.—SPLEEN.

1. Embolism of the spleen and lungs in a case of enteric fever.	Dr. Murchison	242

B.—SUPRA-RENAL CAPSULES.

2. Case of Addison's disease.	Dr. Dickinson	243
3. Tumour of supra-renal capsule.	Dr. Cayley	246
4. Case of Addison's disease of the supra-renal capsules.	Dr. Greenhow	247
5. Cancer of right supra-renal capsule.	Dr. Cayley	250

Page

6.

Unusually large mass of carcinomatous deposit in one of the supra-renal capsules of a child. — Dr. John W. Ogle . 250

Report on the above specimen. — Mr. Richard Partridge, Dr. W. H. Dickinson, Dr. John W. Ogle, Mr. George W. Callender 251

7.

Cyst, with semi-transparent parietes, occupying about a quarter of one of the supra-renal capsules. — Dr. John W. Ogle . 252

C.—THYROID GLAND.

8.

Cancer of thyroid gland, causing pressure on the trachea. — Mr. Henry Smith . . 253

Report on the above specimen. — Dr. Murchison, Dr. George Harley . 253

DISEASES, ETC., OF THE SKIN.

1.

A photograph, coloured from life, of psoriasis diffusa and guttata, affecting the skin over the knees, following a fall. — Mr. Balmanno Squire . 254

2.

A photograph, coloured from life, of impetigo figurata, affecting the skin of the forehead and nose. — Mr. Balmanno Squire . 255

3.

Case of favus cured without epilation. — Mr. Balmanno Squire . 256

		Page
4. A coloured photograph from life of lichen inveteratus.	Mr. Balmanno Squire	258
5. A coloured photograph from life of the hand of a woman affected with scabies.	Mr. Balmanno Squire	259
6. Sequel to a case of true keloid.	Mr. Sedgwick	260
7. A rare form of skin disease:—keloid or molluscum.	Dr. Semple	261
8. Case of true leprosy. A portrait of face, and wax model of arm.	Dr. Thomas Hillier	262
9. A case of cheloid of Alibert.	Dr. Thomas Hillier	266
10. Horny growth on the face.	Mr. Holmes for Mr. Roberts	267
11. Drawing illustrating a remarkable condition of the nail and end of one finger in connection with neuralgia of the same finger, and of the upper arm.	Dr. John W. Ogle	268
12. Photographs of pendulous growths from the surface of the body.	Dr. Murchison for Dr. Henry G. Wright	269

MISCELLANEOUS.

		Page
1. Series of blood-crystals.	Dr. George Harley	272
2. Specimens of tænia medio-canellata.	Dr. Greenhow	272
3. Voluntary muscle in fever.	Dr. George Buchanan	274
4. Abscess in body of rectus muscle from a case of enteric fever.	Dr. Murchison	275
5. Dry gangrene of the right hand, occurring suddenly in a middle aged woman.	Mr. Partridge	276
6. Trichiniasis.	Dr. Robert Liveing	276
7. Fatty tumour from the recto-vaginal septum.	Mr. Spencer Wells	277
8. Case of fatal abscess in the rectus femoris muscle, giving rise to symptoms which were supposed to have been those of sciatica, and treated accordingly.	Dr. Ogle	278
9. Muscles and tendons forcibly pulled from the wrist by machinery.	Dr. Gibb	279

SPECIMENS FROM THE LOWER ANIMALS.

		Page
1. Tuberculous lungs of an antelope (Rietboc; Elcotragus arundinaceus).	Dr. Crisp . . .	279
2. Disease of lower jaw-bone of an antelope.	Dr. Fenwick . . .	280
3. Tubercle of the spleen of a young ourang (Simia satyrus) with wax casts.	Dr. Crisp . . .	280
4. Morbid specimens, casts in wax and drawings, to illustrate the various forms of tubercle in the lower animals.	Dr. Crisp . . .	280
5. Diseased crania of the Quadrumana.	Dr. Crisp . . .	281
6. Diseased renal bodies in a camel.	Dr. Crisp . . .	282

INDEX TO PLATES.

PLATE		PAGE
I.	Atrophy of the Left Cerebral Hemisphere (Dr. John W. Ogle)	5
II.	Cyst in the Cavity of the Arachnoid (Dr. Wilks)	6
III.	Microscopic Structure of Cirrhosis of the Lung (Dr. H. G. Sutton)	39
IV.	Primary Epithelial Cancer of the Epiglottis and Pharynx involving the Vocal Cords (Mr. A. T. Norton)	53
V.	Cancerous Deposit in the Heart (Dr. Peacock)	100
VI.	Colloid Disease of the Peritoneum (Mr. Francis Mason)	128
VII.	a. Microscopic Characters of Fluid from Galactocele (Dr. George Harley)	184
	b. Microscopic Structure of Supra-renal Capsule from a case of Addison's Disease (Dr. Greenhow)	247
	c. Blood-Crystals (Dr. George Harley)	272
VIII.	Transverse Hermaphroditism (Mr. Partridge)	191
IX.	Transverse Hermaphroditism (Mr. Partridge)	191
X.	Fibrous Tumour of Lower Jaw with Microscopic Structure (Mr. Buxton Shillitoe)	223
XI.	Congenital Deficiencies of the Bones of the Skull-cap (Mr. Thomas Smith)	224
XII.	Osteo-myelitis of the Tibia (Mr. Henry Lee)	226

INDEX TO WOODCUTS.

FIG.		PAGE
1.	Encephalocele of the Anterior part of the Skull - -	9
2.	Ditto ditto - - - -	9
3.	Ditto ditto - - - -	10
4.	Ditto ditto - - - -	11
5.	Spina Bifida undergoing Spontaneous Cure - -	14
6.	Tumour Compressing Spinal Cord - - -	22
7.	Ditto, Microscopic Appearances - - -	22
8.	Section of Spinal Cord from a case of Paraplegia after Fever -	34
9.	Encephalocele of Posterior part of Skull- - -	36
10.	Bronchial Cast expectorated during life - - -	49
11.	Bronchial Cast found in Lower part of Trachea after death -	50
12.	Malformation of Heart - - - -	63
13.	Rupture of Fleshy Column of Diseased Mitral Valve -	68
14.	Entire loss of two of Pulmonary Valves - - -	74
15.	Rupture of one of Aortic Valves - - -	78
16.	Diagram of Meso-colic Hernia - - -	139
17.	Diagram illustrating Mr. Teevan's communication on the "Lamina Vitrea" of the Skull - - -	218
18.	Ditto ditto - - -	220
19.	Ditto ditto - - -	220
20.	Ditto ditto - - -	222
21.	Ditto ditto - - -	222
22.	Horny Growth from the Face - - -	267
23.	Pendulous Growths from Surface of Body; Anterior View -	270
24.	Ditto ditto; Posterior View -	271

REPORT.

SESSION 1864-65.

I.—DISEASES, ETC., OF THE NERVOUS SYSTEM.

1. *Obstruction by clot of right middle cerebral artery in a patient who had been suffering from secondary syphilis and who was free from heart disease.*

J. C., æt. 27, a carpenter, was admitted under my care on the 2nd of May, 1863. It appears that on the morning of April 28th he went as usual, and seemingly in good health, to his work; that about 9 A.M. he was suddenly attacked with pain in the head and giddiness, without loss of consciousness; and that at the same time he lost the use of his right arm and of both legs. It was stated that he had been a temperate and healthy man, that he had never before had anything like a fit, or rheumatism, or, in fact, any serious illness, except syphilis. This latter disease he had contracted four years before, and had had secondary eruptions at intervals since.

On admission he was found to be perfectly sensible, but his speech was imperfect. He had in great measure recovered the use of his legs, but his arm continued powerless. Sensation was everywhere perfect. His pupils acted naturally, and his eyesight and hearing were unimpared. His face was slightly drawn to the left, and he protruded his tongue with a slight inclination to the right. He complained only of some giddiness and of aching in the shoulders. His excretions were passed naturally, but the bowels were inclined to be constipated. His tongue was white and moist; his appetite poor. The heart-sounds were natural. He remained for about ten days in much the same state. It was then noticed, for three or four days, that he was very drowsy. Still no material change in his condition occurred until the morning of the 16th, just after my visit. At that time he was complaining somewhat of

pain in the head, and became suddenly insensible, and continued almost perfectly insensible up to the morning of the 18th inst., when I saw him again. At that visit, when loudly addressed, he partially opened his left eye, but took no further notice. There was complete ptosis of the right eyelid, which was said to have existed only since the morning. The pupils acted. The left arm lay perfectly still, but all the other extremities were slightly convulsed at times. His evacuations were all passed unconsciously. The pulse was 80.

He survived ten days, during which time his condition varied but little. During the first half of this period he had intervals of imperfect consciousness, in which he would open his eyes when spoken to, and endeavour even to put out his tongue; but afterwards he became wholly comatose. At first the pupils (though dilated) acted equally to light; latterly they acted a little irregularly, and the day before his death their axes were divergent. The paralysis continued throughout; but towards the close of life all convulsions ceased. The evacuations continued to be passed in bed; but the bowels were only relieved after the use of injections. The pulse gradually increased in frequency, until it attained, the day before death, a maximum of 140. During the last day or two of his life the breathing also became hurried, but unattended with cough, and his face became shrunken and ghastly. He died on the morning of the 28th of May.

Post-mortem examination.—There was the scar of an old wound on the scalp. The internal surface of the cranium was healthy. The arachnoid membrane was somewhat opaque, and there was some turbid fluid in the arachnoid cavity. The pia mater was somewhat congested. The arteries at the base of the brain were healthy, with the exception that the right middle cerebral artery was obstructed by a firm, partly decolourised clot, which completely filled it, just before its division into branches. The middle lobe of the right cerebral hemisphere was softened, and the grey matter of some of its convolutions congested. The grey matter of the two central convolutions was paler than usual, and somewhat yellowish — the boundary between the grey and white matter being ill-defined. The grey matter of this portion of the brain presented, under the microscope, numerous compound granular cells; and similar cells, but in smaller numbers, were discovered in the adjoining white substance. The left corpus striatum contained a cavity about one-third of an inch in diameter. This had vascular walls, and contained some turbid fluid, which presented numerous large compound granular cells with some nerve-cells and blood-corpuscles. The rest of the

brain was healthy. The lower lobes of both lungs were congested and in a state of lobular pneumonia. The heart was in every respect healthy, the valves being entirely free from vegetations. The right ventricle contained a large quantity of yellow fibrinous clot, extending into the pulmonary artery. The capsule of the liver was thickened in patches, but the organ itself, beyond being a little fatty here and there, was healthy. The spleen was somewhat large, and its capsule was thickened. The kidneys were rather small, and presented on the surface a few irregular depressions. The remaining viscera were in a healthy condition.

Remarks.—The above case is chiefly interesting in two points of view. *First,* there was obstruction by clot of one of the middle cerebral arteries, without heart disease, or, so far as could be detected, any source of embolism. The clot had doubtless formed in the situation in which it was discovered.

Second, the patient had suffered until within a short time of his death from secondary syphilis, a condition which I have shown on a former occasion (*Path. Trans.* vol. x. p. 44) to be a not improbable cause of the obstruction by clot of the cerebral arteries.

In comparing the history of this case with the appearances noted on dissection, there can be little doubt, I think, that obstruction of the right middle cerebral artery had produced the sudden change of symptoms which took place on the 16th of May, and led to the disorganization on the right side of the middle lobe of the cerebrum. Whether, however, his first attack of paralysis (which evidently had some connection with the cavity found in the left corpus striatum) had been the result of arterial obstruction on the left side, or of an ordinary apoplectic attack, must remain doubtful. Against the first view must be placed the fact that no obstruction of the corresponding middle cerebral artery was detected; against the second, the fact that no remains of blood, no orange-tinted discolouration of the parieties of the cavity, and no hæmatoid crystals were recognized. It is possible that obstruction of some of the minute terminal branches of the artery may have been, in this case, the cause of obstruction.

I have not thought it necessary to give the details of treatment. It is sufficient to say that the treatment was of an ordinary character, and that it was wholly unattended with beneficial results.

Dr. Bristowe, 1*st of November,* 1864.

2. *Ulceration of the inner surface of the cranium in connection with a carcinomatous growth of the brain from a case of mania and hemiplegia.*

The patient, Jane E., was admitted into the Somerset Lunatic Asylum, in January, 1852, suffering from hemiplegia of the *right* side, and mania. Her disposition during her life in the Asylum was irritable, but kindly. Her bodily health was indifferent, and she had suffered from occasional paroxysmal attacks of excitement. In May of the present year (1864) she was removed to the Infirmary complaining of extreme weakness. In June she had an attack of jaundice and ascites. These symptoms increased, and she died on the 8th of July.

Post-mortem examination.— Cranium.—The cerebral vessels, especially those on the right side, were very congested, and a portion of the superficial parts of each cerebral hemisphere (to about the size of a hazel-nut) was infiltrated with purulent fluid, and occupied by a soft reddish-brown growth, the surrounding brain-tissue being dark and inflamed. The cerebral membranes were natural. On the inner table of the skull, corresponding to the disease of the brain, were two excavations produced by ulceration. The one on the left side was very slight; the other on the right side was much deeper, and about equal to a shilling in diameter, its edges being surrounded by new bone formations in the shape of numerous very fine and sharp spicula, and, to a certain degree, by very firm fibrous tissue adherent to the bone. This depression was occupied by soft brownish-red material of the same nature as that observed in the brain-tissue; but the bone, where ulcerated, was not at all softened. The cavity occupied the inner surface of the bone where traversed by the groove for the middle meningeal artery, which was in consequence at one part quite obliterated by it. The outer surface of the skull, corresponding to one of the excavations, was porous and slightly ulcerated.

Spinal column.—About an ounce of clear fluid was found in the spinal canal. The spinal cord was healthy.

Thorax.—The lower half of one lung was much congested. The heart was natural.

Abdomen.—The abdominal cavity contained much fluid. The liver weighed one hundred and eighty two ounces and was greatly enlarged, and occupied by carcinomatous tumours, as was also the uterus.

Microscopical examination of the brownish deposits in the brain showed, in addition to much fat, plates of cholestearine and rounded bodies containing margarine, numbers of large, granular, and opaque nerve-cells,

DESCRIPTION OF PLATE I.

Illustrating Dr. John W. Ogle's case of Atrophy of the Left Cerebral Hemisphere (p. 5).

Fig. 1. shows the chasm on the upper surface of the left hemisphere, widely opened by a glass rod, and its walls traversed by large bloodvessels; natural size.

Fig. 2 represents the upper surface of the brain, one half of the natural size. It shows the relatively small size of the left hemisphere and the situation of the chasm on its upper surface.

Fig. 1.

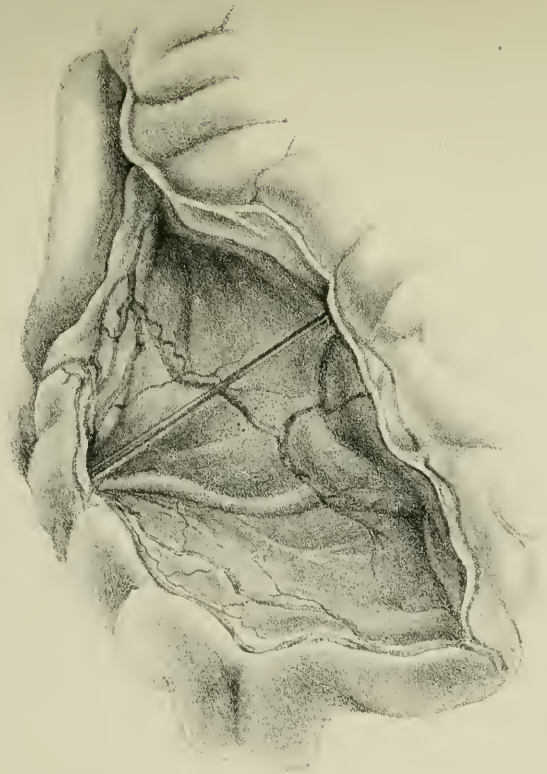


Fig. 2.

Dr Westmacott del. T. West lith.

W. West imp.

a few granular corpuscles, along with much granular matter, and numbers of round and oval nucleated cells, some being caudate, such as are often found in encephaloid growths, and some containing two and three nuclei. A few very large oval bodies full of granular opaque matter, and of about three or four times the size of pus-globules were seen. The deposit connected with the ulcers of the cranium presented similar cells, in addition to firm fibrous tissue.*

Dr. JOHN W. OGLE, *15th of November*, 1864.

---

3. *Atrophy of the left cerebral hemisphere with atrophy of the arm of the opposite side of the body, from a confirmed epileptic who died of phthisis.*

The patient, C. E., a man, æt. 29, who had been subject to epilepsy from childhood, was admitted into the Wells Lunatic Asylum in October, 1860. The arm of the right side was much smaller than the left one in diameter, measuring four inches and a-half below the insertion of the deltoid muscle, whilst the left one was five inches and three-quarters, and much shorter, measuring twenty-seven inches, whilst the left one measured thirty inches. The right wrist was firmly contracted, and was only four inches and three-quarters in circumference, whilst the other was six inches. During the year 1861 the patient had had forty-nine epileptic attacks; forty by day and nine by night. During 1862, forty-three; twenty-five by day and eighteen by night. During 1863, thirty-eight; thirty-three by day and five by night: but in 1864 (the present year), up to September, he had only four fits. He was rational in the intervals between his attacks, and assisted the attendants in cleaning the corridors of the Asylum; but was violent when the fits came on. He died of pulmonary phthisis.

Post-mortem examination.—The skull was found to be quite natural in formation and shape, measuring twenty inches and a-half in circumference when the scalp was removed, eleven inches in an antero-posterior, and ten inches in a transverse direction without the scalp. The dura mater was natural. On removing the membranes on the left side a quantity of fluid escaped. The brain was found to be very unsymmetrical (see Plate I.). The encephalon weighed altogether forty ounces, the brain, without the cerebellum, weighing thirty-four ounces; but the left hemisphere was much smaller than the right one and only weighed seven ounces. In addition to the left hemisphere being generally smaller in size than its fellow, there was complete

* I have to thank Dr. Boyd for the particulars of this case.

absence of some of the superficial convolutions on its upper and posterior surface; owing to this a deep chasm was produced, which, when widely opened, presented a cavity of the size of a large walnut, lined by apparently thickened arachnoid membrane, traversed by large blood-vessels (Plate I). This had been seemingly produced by absorption and cicatrization following extravasation of blood. The middle lobe of the brain near the above-mentioned cavity was much softened; but the brain was otherwise healthy in substance. The lungs were occupied by tubercular deposits and vomicæ. For the details of this, as of the former case, I have to thank Dr. Boyd, Resident Physician at the Lunatic Asylum at Wells, who also sent me a photograph of a patient now in the Asylum having a similar deformity of the right arm (shortening and contraction), and in whose case the left side of the cranium is flattened.*

Dr. John W. Ogle, *15th of November*, 1864.

---

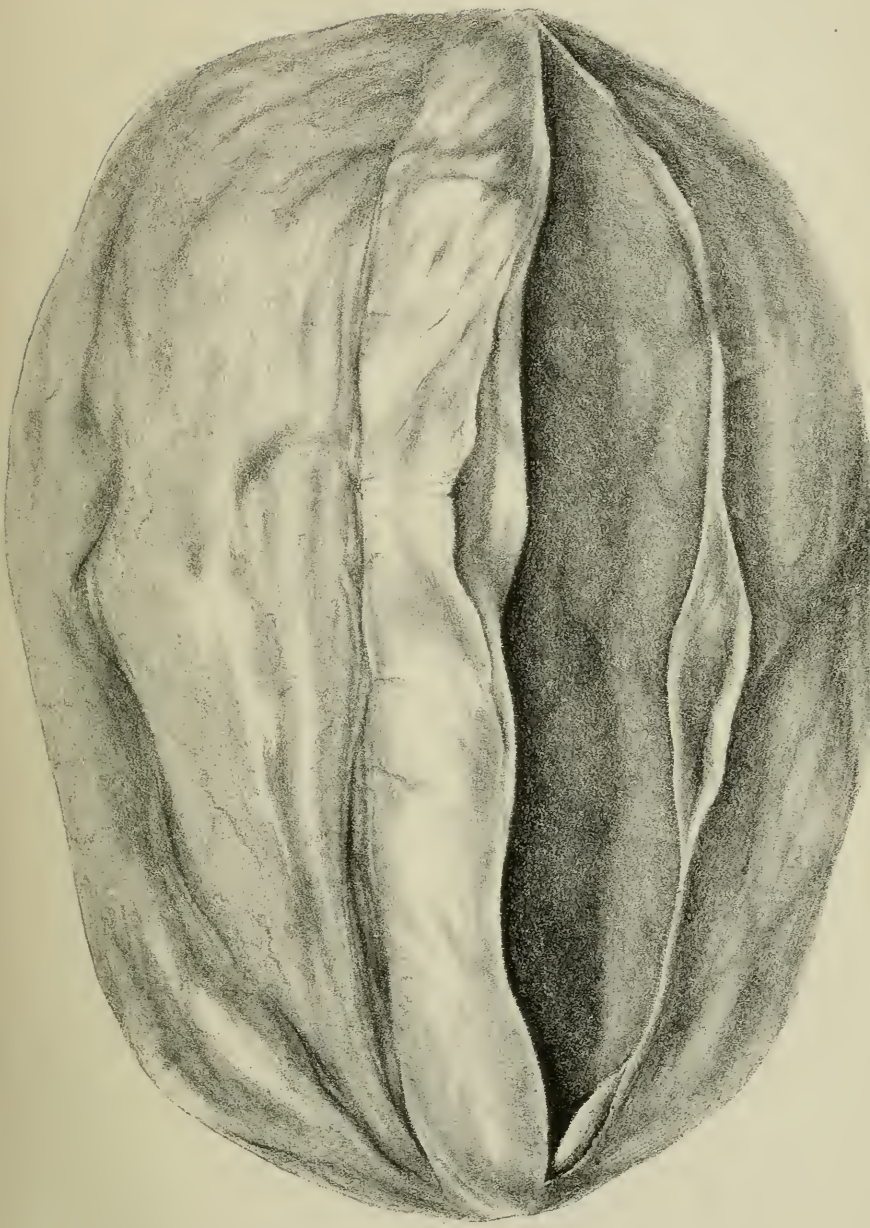
4. *Cyst in the cavity of the arachnoid.*

This was found in the body of a young man who was brought from the Workhouse to Guy's Hospital dissecting room. On removing the calvarium the dura mater on the right side felt boggy, and after cutting the membrane all round in the usual manner, it was found firmly adherent to the cerebral hemisphere. On removal of the dura mater the existence of a cyst on the right side was very evident (see Plate II.); but so incorporated were the edges that it appeared like a cyst in the membrane itself. On cutting through the upper surface there were found within it three or four ounces of an opaque, glistening fluid, which, on standing, deposited about half-an-ounce of cholesterine; but no blood-crystals were seen. It was then found possible to separate the outer wall into two layers, the external one showing itself to be the perfect dura mater, and thus, if it could have been completely stripped off, the cyst would have been left free. It had thus been

* This photograph was exhibited to the Society. I may here allude to a case which I brought before the Society on a former occasion, of atrophy of one hemisphere of the brain (without any cyst) with atrophy and contraction of the opposite arm, in a boy aged 13, see vol. x. p. 38; also to another of similar atrophy and contraction in the case of a man aged 62, in whom a large cyst existed at the base of the left ventricle on the opposite side, see vol. vii. p. 8. I may also refer the Society to some observations made by Dr. Boyd in several cases of contraction of the limbs associated with degeneration on the opposite side of the brain, published by him in the thirty-ninth volume of the *Trans. of the Royal Med.-Chir. Society* (1856).

DESCRIPTION OF PLATE II.

The plate illustrates Dr. Wilks's case of Cyst in the Cavity of the Arachnoid (p. 6).



placed on the right hemisphere of the brain and corresponding in shape and form to it, with its upper surface closely adherent to the dura mater and its lower to the brain. The adhesion between the latter was by tough fibrous tissue, which left each surface shreddy on separation. There was a bony plate on one spot, as also in the dura mater on the left side. The interior of the cyst was of a white colour and quite smooth; as the upper and under surface were nearly plane, they joined at an acute angle; here they were firmly blended, especially towards the middle line, where, externally, they joined the dura mater and falx cerebri. On this side the upper and lower surfaces were connected by some thick bands of tough consistence, and of the same material as constituted the walls of the cyst.

The young man had been an inmate of a workhouse for two years, during which time he had been looked upon as half-witted, being fond of frolicking and tumbling about; when questioned he answered with rude sharpness. He had no active cerebral symptoms and never had any fits, nor was known to have received any injury. His history could be traced back for seven years, and during this time he had never had any illness.

The explanation of the formation of these cysts in the arachnoid cavity was given many years ago by Mr. Prescott Hewett.* He showed how effusions of blood upon the arachnoid assumed a membranous character, became adherent to the surface, and, if in any quantity, how a cyst might be formed. Another opinion had been given, that such membranes are the result of organized lymph arising from a previous inflammation; but of this there has never been any proof, whilst the observations of Mr. P. Hewett appear to be conclusive. In other cases it is true that the cyst has not been so firmly adherent to the brain, but this, probably, is no argument against the supposition of its having originated in blood, since it is well known how in a blood-vessel, or other serous surface, the remains of a blood coagulum will become incorporated with the surface. There may be no theoretical objection against such a cyst originating in an inflammatory effusion, but, since the blood theory is all-sufficient, there is no reason to adopt another. The absence of history of any injury would lead rather to the supposition of a sanguineous than an inflammatory effusion, seeing that the former might occur spontaneously whilst an idiopathic arachnitis is altogether unknown. The calvarium was large

* *Medico-Chirurgical Transactions*, vol. xxviii.

and showed that the fontanelle had been open for some time, as the space was occupied by a separate bone. There were also ossa triquetra in other parts. Dr. Samuel Wilks, 15*th of November*, 1864.

---

5. *Three examples of Encephalocele of the anterior part of the skull.*

In the thirty-ninth volume of the *Medico-Chirurgical Transactions* (1856), Mr. Zachariah Laurence related a case of encephalocele of the back of the head, and drew up a table of all the recorded cases of the affection. These were seventy-five in number, and of these fifty-three occurred in the occipital region, seventeen in the frontal region, and five in the parietal and temporal regions. Since that date several cases of encephalocele of the back part of the head have been recorded in the journals, but as far as can be ascertained only two cases have been recorded as occurring in the anterior part of the head. The subject of one of these cases was exhibited to the Pathological Society, by Mr. Shaw, on the 1st of December, 1857, and the case is recorded, with an illustration, in the ninth volume of the *Pathological Transactions* (p. 1). The patient was an infant aged three months, and the encephalocele presented at the root of the nose. The child at that time enjoyed good health and is still alive. The second case was recorded, by Mr. William Bird, in the *Lancet* of the 3rd of August, 1861. In this case the tumour was of large size involving the left orbit and forehead. The left half of the frontal bone, the whole of the left parietal, and portions of the temporal bone were absent, and no traces of the left eye-ball existed. (Fig. 1.)* The tumour was composed of softened brain-substance, and was supported by the squamous portion of the temporal bone, which was pushed forwards and outwards at right angles to the left malar bone. Over the cribriform portion of the ethmoid was a large cyst, filled with yellow transparent fluid. There was a hare lip and cleft palate. The child lived four days.

The cases exhibited to the Society were three in number, one being a *post-mortem* specimen and the others living children.

1. The specimen was from a case which occurred in the practice of of Dr. Riley, of Charlwood Street, and consisted of the head of a child

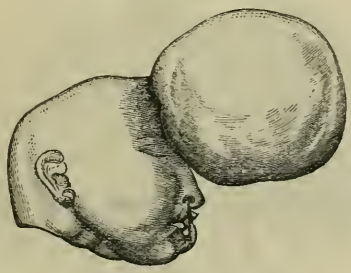
* The position of the tumour is reversed in the woodcut, and made to appear on the right side instead of on the left (*vide* Mr. Bird's report.)—*Lancet*, 3rd of August, 1861.

born at full term, which presented a large tumour of the forehead, measuring, when distended, twelve inches in circumference transversely,

Woodcut 1.

and ten inches in circumference from before backwards. (Fig. 2.) The tumour was the presenting part, and simulated the breech very closely.

Woodcut 2.



On consultation with Dr. Chambers it was punctured, when about a tea-cupful of bloody fluid escaped, flowing apparently from a space between the scalp and the dura mater, and being the result probably of extravasation from pressure. A deeper puncture gave exit to about a

quart of clear serous fluid, upon which the tumour collapsed in great part and delivery was effected.

The child lived ten hours, fluid and particles of brain-matter coming away from the puncture during that time.

The tumour on being laid open proved to be an encephalocele, the dura mater being bulged out between the halves of the frontal bone, which were widely separated. It contained a portion of the brain, which was exceedingly soft. Dr. Riley and Dr. Chambers believe that there was no communication between the ventricles of the brain and the tumour, and if so this is unusual, since, in most observed cases, the communication is undoubted.

The child was otherwise well formed, with the exception that it presented a single hare-lip immediately to the right side of the median line.

2. The second case was that of a little girl, æt. 11, who, at birth, had a pulsating tumour at the root of the nose, evidently dependent

Woodcut 3.

This figure is taken from a photograph in the possession of Mr. Shaw, under whose care the girl is at present (July, 1865) a patient in Middlesex Hospital.

upon some communication with the interior of the skull, and probably connected with the anterior lobes of the brain (Fig. 3). The child had been first seen by Mr. Heath, when five years old, and a photograph of it at that age was exhibited, showing that no material alteration had taken place since that date. The tumour had expanded the nasal bones and was presumed to depend upon some want of development of the base of the anterior fossa of the cranium, and probably of the cribriform plate of the ethmoid. The tumour was flattened but had a projecting point, giving much the appearance of a second nose at the root of the natural one.

The President (Mr. Prescott Hewett) supplied some details respecting the early history of this case, which he recognized. The child was taken soon after birth to Mr. Arnott to be operated on for a supposed vascular tumour at the root of the nose; he, however, declined to interfere with it. Mr. Hewett had alluded to the case in his lectures (unpublished) at the College of Surgeons, and the case was exhibited to the Court of Examiners of the College. He mentioned also a case of fatal error with regard to a similar case which had come to his knowledge; and a case at St. George's, in which the removal of a small tumour from the wall of the orbit, was followed by the escape of some cerebral matter, but the patient fortunately recovered.

Woodcut 4.

3. In this case the child was three years old, and the protrusion was almost precisely similar to that in the second case as to position, but the tumour was more prominent and about the size of a very large marble (Fig. 4.). The tumour was congenital and the growth appeared to have increased only in proportion to the child's age. During the first four months of life the sac appeared to be nearly transparent, and at the end of that time Mr. Paget, under whose care the child then was, tapped it, and evacuated a considerable quantity of fluid. Afterwards iodine injections were used on three occasions, and caused so much inflammation that serious consequences were apprehended. After this, however, the walls gave way, and a large quantity of fluid, looking like dirty water, was evacuated. Within twenty minutes the tumour refilled, and since that time nothing has been done. The child is in good health and appears to be of average intellect and suffers no inconvenience except from the deformity, which, however, does not admit of remedy.

Mr. Christopher Heath, *6th of December*, 1864.

---

6. *Encephalocele of the posterior part of the skull.*

The case occurred in the practice of Dr. Tebay, of the Belgrave Road. The deformity of the head of the child obstructed the labour and the forceps was employed for its extraction. The child survived nearly twenty-four hours.

The occipital region of the head presented a soft tumour equal in size to a very large orange; the rest of the body was well formed and plump. On dividing the integuments in the middle line over the tumour they were found to blend insensibly with the dura mater; the expanded plate of the occipital bone being entirely deficient or replaced only by connective tissue. The arachnoid was well defined, and the vessels of the pia mater were extraordinarily numerous, large, and fully injected with blood. More than half the cerebral mass, comprising the whole of the posterior and part of the middle lobes of the hemispheres of the cerebrum was contained in the tumour. The consistence of the brain was somewhat soft, but the distinction between white and grey substance was perfectly evident.

No abnormal characters were presented by the spinal cord. The

medulla oblongata was of unusual breadth. The fourth ventricle was correspondingly wide and shallow; and at its upper part it was bounded by two elevations, separated by a slight fissure, which appeared to be rudiments of the cerebellum. The pons Varolii was entirely absent. From the upper part of the medulla oblongata, and especially connected with the anterior pyramids, a large number of nerve-fibres passed up on each side into the substance of the cerebral hemispheres; these were the only traces of the peduncles of the cerebrum. On removing the membranes of the brain, the hemispheres fell apart by their own weight and no traces could be seen of corpus callosum, fornix, white or grey commissures. It was impossible to distinguish the corpora striata, optic thalami, or corpora quadrigemina, as separate masses, but from the manner in which the optic nerves (there was no optic commissure) dipped into the inner and lower part of the hemispheres, there was reason to believe that these parts were blended with the hemispheres themselves. The lateral ventricles were of very large size.

There was a remarkable malformation of the heart in this case which will be found described in another part of the *Transactions*.

Mr. Christopher Heath *for* Mr. Henry Power,
6th of December, 1864.

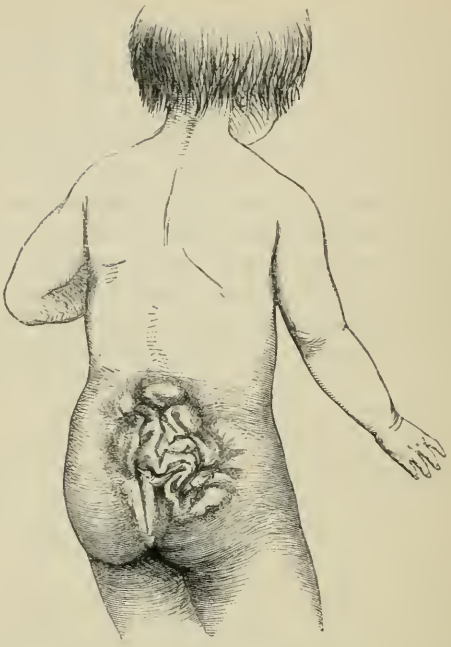
---

7. *Case of spina bifida in progress of spontaneous cure.*

The subject of this case is an infant æt. 12 months. She was first seen a few days after birth. She then had a tumour in the lumbo-sacral region the size of a child's head. It was of a florid red colour, and traversed in every direction by large vessels. It was distended with fluid, and seemed to be on the point of bursting. There was no paralysis of the inferior extremities, and the child was in every other respect healthy and well formed. With the view of relieving the tension of the cyst, it was proposed to make a few minute punctures, but the mother objected to any interference, and consequently no treatment was adopted. The child was brought to King's College Hospital, in December, 1864.

The tumour has now nearly disappeared, the contained fluid is entirely absorbed, and the skin which covered it is thrown into numerous folds over the site of the deficiency in the spinal column (Fig. 5.).

Woodcut 5.



The integument has assumed a perfectly natural appearance, and can be freely handled without in any way inconveniencing the child, who is robust and in perfect health. The long margin of the opening in the spinal column seems to be rounded off, but this cannot be clearly made out on account of the convoluted folds of integument which are firmly attached to it.

Dr. W. G. Playfair, 20*th of December*, 1864.

---

8. *Disease of the brain of a tubercular nature associated with loss of the use of language.*

A man, æt. 30, had been for many months under my care on account of disease of one ankle joint. I had performed Pirogoff's am-

putation and he had returned home, but some months later it was necessary to admit him again, with an abscess consequent on carious disease of the left sacro-iliac synchondrosis. From the latter he had profuse suppuration and became greatly reduced in health. He was confined to his bed.

One day, at my visit, I was informed that the man had been queer in his manner, and either could not or would not speak. He had no other cerebral symptoms. He sat up in bed, put out his tongue, obeyed directions, &c., but when spoken to looked at the questioner in a vacant manner, and made no effort to reply. As it was known that he was anxious to prolong his stay in the Hospital, the new symptoms were attributed, by most who saw him, to simulation. During the next week he remained in much the same condition and never spoke to any one, excepting that when much pressed for an answer he would now and then utter the expression, "Can't." After this he got worse, became restless and violent, and had a succession of epileptic seizures. He also lost control of his sphincters. He lived for three weeks after the loss of speech was first noticed, during the last few days of which he was in an insensible state and subject to attacks of epileptiform spasms (general) every few hours.

At the *post-mortem* examination tubercular deposit was found beneath the arachnoid at two distant parts. In the extremity of the posterior horn of the *right* lateral ventricle was an isolated mass of crude tubercle, about the size of a horse-bean. Adjacent to this mass the brain-substance was somewhat softened. In the left fissure of Sylvius there was much more extensive disease. The arachnoid was thickened and opaque, and its layers adhered. Beneath it, and surrounding the trunks of the vessels, were several ill-defined masses of opaque material like tubercle, and around these was exudation, which matted all the parts together. On stripping off the pia mater the cortical substance of the brain adhered to it and was torn. This latter was very decidedly softened. The diseased condition involved especially the anterior and upper part of the sphenoidal lobe, but it extended from this upwards and inwards to the island of Reil. The specimen shown to the Society consisted of the entire brain. There was no disease in it excepting that described. Both lungs contained tubercle, and the left sacro-iliac synchondrosis was found in a carious condition.

Without expressing any opinion as to the views held by M. Broca and Dr. Hughlings Jackson as to the seat of the function of language, I may remark, that in this case the disease was close to the part in

which that function is supposed to be, and that the earliest symptom of cerebral disease noticed was inability to employ speech.

Mr. Jonathan Hutchinson, *3rd of January*, 1865.

---

9. *Right hemiplegia, with complete loss of speech; partial improvement. Attacks of epileptiform convulsion. Increase of paralysis. Death. Brain healthy. Granular degeneration of spinal cord.*

W. R., æt. 44, married, silver-polisher, was admitted into King's College Hospital under Dr. Beale, on November 10th, 1864, for chronic rheumatism. He had well-marked arcus senilis in both eyes. A few hours after admission he had sudden right hemiplegia with almost complete unconsciousness for several hours. The next day he was quite sensible, but unable to speak or put out his tongue, and the right arm and leg were almost completely paralyzed. Reflex action was increased in the paralyzed leg; but became normal in a few days. Face drawn to the left side; pupils unequal. On the eighth day he had an epileptic fit, the right side being most convulsed, and the right pupil dilated and insensible to light. The palsy of the limbs and speech gradually improved. On the twenty-first day he put out the tongue, and on the twenty-sixth day he could move the right arm freely and articulate pretty well. On the thirty-ninth day he had a fit affecting the left side. The next day he was sensible, but again unable to put out his tongue, and had much less power over the arm. On the forty-second day he had two more fits, one affecting the right side. On the forty-sixth day he was quite unable to articulate, and the paralysis of the right arm and leg was all but complete. He passed his motions and urine under him throughout. Bedsores gradually formed about the hips and sacrum, and he lost flesh very much. He became gradually weaker, remaining quite sensible, and died on the 14th of January, 1865, having been sixty-five days in the Hospital.

Post-mortem examination. — Sub-arachnoid fluid very abundant. Arachnoid slightly opaque. Brain and medulla oblongata very firm and perfectly healthy. Several portions of the spinal cord were found to be in a condition resembling that termed by Mr. Lockhart Clarke transparent granular degeneration. They were of moderately firm consistence, and distinguishable from the healthy portions of the cord by their translucence and reddish-grey colour. Their position was, roughly, as follows:—one in the left lateral tract, at the commencement

of the dorsal region; two in the middle dorsal region, one of them being in the right lateral tract and the other lower down, and involving the central part of the cord; and two in the lower dorsal region, both involving the antero-lateral tract and one of them on the right side. On microscopical examination no healthy nerve-structure was seen in the diseased parts, which consisted of finely granular fibres, granular matter, and numerous corpora amylacea. The minute vessels were in a state of fatty degeneration. There were a few small fibrinous beads on the aortic valves. At the apex of the left lung was a cavity surrounded by tubercular deposit. The other organs were healthy.

Dr. Morris Tonge, *7th of February*, 1865.

---

10. *Extensive hæmorrhage into the right hemisphere of the brain, from a patient who died in epileptiform convulsions.*

The subject of this case was a gentleman, æt. 56, unmarried, plethoric, of a full habit of body, a free liver, but whose general health was quite up to the average.

He dined out on the day preceding the fatal attack (January 16th), and on the following morning partook only of a little tea for breakfast (by no means an unusual circumstance), and sat quietly reading the newspaper until just before three o'clock, when he retired to his bed-room to wash his hands for dinner. He, however, spoke to his maid-servant as he passed out of the sitting-room, and appeared to her to be in his usual health. Half-an-hour later I was accidentally passing his house, and went in to inquire after him. His dinner was then untouched on the table. The servant expressed surprise at this, and thought that her master must have gone to sleep. She immediately proceeded to his bed-room and knocked loudly at the door; but receiving no answer, she returned and said she could hear him "snoring." Thinking he must be unwell, I went at once with the girl to his room, and there found him stretched out insensible on the floor. His breathing was loud, but certainly not stertorous; pulse quick; pupil of left and only eye contracted, and a little blood flowing from the mouth.

I raised his head, loosened his neck-tie, and administered a little wine and water. In a few minutes his breathing became easier, and he made an effort to move and speak. While I was directing pillows to be placed under his head a violent epileptic convulsion seized him, which lasted quite ten minutes. I then noticed that the left side

was paralyzed. In from fifteen to twenty minutes there occurred another seizure, and this was again succeeded by an interval of rest; other fits followed in tolerably regular succession. As near as could be ascertained, twenty-six fits occurred in thirty hours; toward the end they became weaker, but lasted longer, and in the last fit he died.

The first twelve hours he readily and easily swallowed liquids, and the breathing in the intervals of quiet became almost natural, the pulse varying from 90 to 118. There was, however, partial ptosis of the left eyelid, with a very contracted pupil. (The right eye I removed nearly five years ago.)

Dr. Salter assisted me at the *post-mortem* examination, which took place eighteen hours after death. There was great lividity of the head and face, and in the right temporal region the appearance of a contusion, probably where he had struck himself in falling. On opening the skull and removing the brain, a great quantity of clotted blood escaped from a wound in the right hemisphere, on a level with the section of the skull. The clots that thus escaped from the opening in the side of the brain remained behind in the base of the skull when the brain was taken out, and, as well as we could judge, amounted to about three ounces of blood.

On opening up the orifice from which the blood had escaped, it was found to communicate with a large cavity in the white substance of the hemisphere, extending from its anterior to its posterior extremity, and filled with clotted blood. The blood had evidently ploughed up the brain-substance and made for itself this cavity, the surface of which was rugged, both white and grey substance being completely broken down and mingled with the blood. In this cavity there must have been at least two ounces of blood, so that, altogether with this and that which had escaped into the base of the skull, there could not have been less than five ounces effused. Whether the point of escape was produced by the saw, or had existed before death, from the blood making for itself a vent and thus escaping between the brain itself and the interior of the skull, may be uncertain.

The walls of the small arteries of the pia mater were found, on examination under the microscope, to be quite granular and in a state of fatty degeneration. This unusual amount of hæmorrhage was probably due to the epileptic convulsions, which succeeded each other so rapidly from the time of the first seizure till death (thirty hours after), and some of which lasted without intermission for twenty minutes. Certainly nothing could be more calculated to produce fresh bleeding than

the state in which the circulation was thrown on the occasion of each rapidly succeeding fit, and it is probable that fresh blood was thus added to the original amount as the fits were repeated.

The interest of this case hinges upon the extensive destruction of brain-substance, and the large amount of hæmorrhage. It is a little remarkable, that my patient's relations never heard of his having had, nor do they believe he could have had, a fit at any former period of his life. However, I may add, that during the summer of 1859 he lost the sight of his right eye from destructive internal inflammation, accompanied at one time by much pain, and at that period he was treated for rheumatism, which extended down the right side of the body.

It is not improbable that the sight of the right eye was lost during a slight epileptic seizure, of which he was himself unconscious, happening about this time.

Early in the following year, 1860, he placed himself under my care, and finding the sight of the left eye threatened, I recommended enucleation of the right eye-ball. This operation was performed, and the patient made a good recovery; the sight of the left eye improved, and remained perfect up to the time of the seizure above narrated. Upon examining the left retina, I observed a few minute, but quite recent, apoplectic spots distributed over it, but otherwise the eye-ball was perfectly healthy. The mass which filled up the right orbit was wholly composed of fat and connective tissue, and the optic nerve had been converted into a very thin, but strong fibrous cord, not a trace of nerve structure remaining. Loss of speech took place simultaneously with the epileptic seizure; but consciousness certainly returned for a few minutes between the first and second fit, for he attempted to say something to me, but was unable to articulate. Dr. Jackson's experience leads him to associate loss of speech with hemiplegia of the right side; whereas M. Broca has found it more frequently associated with the affection of the left side. In this case loss of speech was associated with hemiplegia of the left side of the body and destruction of the right side of the brain. The left hemisphere was slightly congested, but nearly normal. The body was not further examined; but upon emptying the bladder with a catheter before death, the urine was found highly albuminous. Mr. Jabez Hogg, 21*st of February*, 1865.

---

11. *Atrophy of the brain from an idiot.*

The patient was a boy, æt. 16, who died in the London Fever Hospital on February 23rd, 1865, of lobular pneumonia. He had been idiotic all his life. He had an idiotic expression of countenance; but there was nothing very remarkable to be seen in the conformation of the head except that it was unusually small.

On *post-mortem* examination the brain was found to be remarkably atrophied. There was a very large quantity of clear serum beneath the arachnoid, elevating this membrane at some places several lines above the convexity of the convolutions. The convolutions were small and shrivelled, and separated by wide sulci filled with fluid, into which the point of the finger could be inserted. The lateral ventricles were very capacious—each contained about two ounces of clear serum. The foramen of Monro measured five lines in diameter. There were between two and three ounces of serum at the base of the brain. The brain and cerebellum, when freed from fluid, weighed only twenty-five ounces avoirdupois. Unfortunately they were not weighed for five days after immersion in methylated spirit 60° over-proof. Another brain, after immersion for the same period in spirit of equal strength, was found to be reduced in weight, from forty-two ounces and a-half to thirty-six ounces and a-half avoirdupois. On the supposition that a similar reduction took place in the case now recorded, the brain would originally have weighed twenty-nine ounces and one-ninth.

Dr. Murchison, 21*st of March*, 1865.

---

12. *Disease of the temporal bone, and abscess of the cerebellum.*

T. E., a young man, æt. 18, under the care of Dr. Sieveking, in St. Mary's Hospital, had, for a fortnight before admission, suffered extreme pain in the right ear, in the head, the face, and down the spine.

When first seen the skin was hot and dry; the pulse 80, full; the pupils dilated and scarcely answering to light. Pain in the head was intense, but somewhat relieved by pressure; there was no vomiting, nor any tendency to such, except when sitting up.

Some three days afterwards severe shivering set in, the pupils became strongly dilated and fixed, the vision double, the pulse dropped to 70, and the pain still continued.

The following morning the symptoms were greatly modified, the patient slept calmly for the first time in three weeks, the pain was wonderfully subdued, but the pulse, still 70 in the minute, decidedly weaker.

On the same night he died, having shown throughout no actual delirium, and no paralysis whatever.

At the *post-mortem* examination the dura mater was found much injected, particularly upon the right side.

Lymph was deposited over the whole of the inter-peduncular space and pons Varolii. The right hemisphere of the cerebellum presented an abscess extending almost through its substance, and containing in front thick, healthy pus, but posteriorly dark, grumous, broken-up brain-tissue. In addition, the right seventh nerve was highly inflamed, and the cavity of the tympanum occupied by thick pus, its osseous roof being softened, but no escape beneath the dura mater.

The membranous labyrinth, examined by Mr. Hinton and Mr. Norton, was somewhat thickened and yellow in the vestibule, but appeared normal in the cochlea and semicircular canals.

Mr. A. T. Norton, 21*st of March*, 1865.

---

13. *Tumour pressing on the spinal cord.*

This specimen was taken from a woman, æt. 46, who died 7th of March, in the Middlesex Hospital, under the care of Dr. Stewart. Her symptoms began rather more than twelve months before her death with a fixed pain in the left iliac region, worse at night. This continued without intermission, and six months afterwards she began to feel formication in the lower extremities, and had a sensation as if a cord were tied round her abdomen. This was soon followed by a gradually increasing loss of power in the legs, commencing in the left. She did not notice any involuntary startings or twitchings. She was admitted into the Hospital 14th of February; there was then almost complete loss of power of motion in both legs; sensation was also very imperfect, especially in the left leg, and before death it was completely destroyed.

The legs occasionally started. She still continued to suffer from pain in the left iliac region. Soon after admission the bladder and sphincter ani became paralyzed, and she died on 7th of March from inflammation of the bladder and bed-sores.

On *post-mortem* examination the body was excessively fat. The bones

of the spinal column were normal. Corresponding to the interval between the tenth and eleventh dorsal vertebræ an oval tumour was found

Woodcut 6.

attached to the inner surface of the dura mater on the left side (Fig. 6);

Woodcut 7.

its long diameter was one inch and a-quarter, its greatest depth five lines; it occupied the interval between two spinal nerves; its surface was

smooth, and appeared invested by the arachnoid; it did not adhere to the surface of the cord. The cord itself was here much compressed, and its left side hollowed out by the tumour; its substance was reduced to a soft, white pulp. Above and below the cord was normal. The tumour itself was white in colour, very soft, resembling in consistence the soft matter which may be squeezed from epithelial cancers. On microscopical examination it was found to consist of nucleated fibres and fibre cells, arranged in a remarkable manner in concentric rings, the centre of which was occupied by a group of nucleated cells and nuclei. The centre of many of the larger systems was filled by a solid shining mass, which was dissolved by acetic acid, and appeared to be formed by a calcified cell (Fig. 7).

With the exception of inflammation of the bladder and pyelitis of the kidneys the other organs were normal.

Dr. William Cayley, 21*st of March*, 1865.

---

14. *Gliomatous tumour of the brain.*

I am indebted to Mr. Churton, of Erith, for the history of this case. The specimen was taken from a little girl, æt. 2, who died January 16th.

She had always been quite healthy till about six months before her death, when it was noticed that she began to droop her head towards the left shoulder, and soon afterwards to complain of occasional pain in the back of the head; this was followed by rigidity of the muscles of the left side. She was then resident in Ireland, and the disease was looked upon as some affection of the spinal cord. She continued to get worse, and in December was brought to London, and Dr. West was consulted, who diagnosed the existence of a tumour at the base of the brain. Mr. Churton first saw the case on the 8th of December. The child was still tolerably well nourished, was very drowsy, and could with difficulty be roused. The left arm was rigidly flexed, and the fingers were bent into the palm of the hand and could not be extended. There was also rigidity of the muscles of the left foot and leg. The pupils were contracted and equal. The child constantly rolled its head from side to side, and occasionally ground its teeth. Repeated attacks of tetanoid spasms occurred, affecting the whole body. The child now rapidly emaciated; both eyes became amaurotic; the lower half of the right cornea ulcerated; the spine became permanently arched backwards and to the left side, and the flexors of the right arm and leg became nearly as rigidly

contracted as those on the left side. On the 16th of January the patient died.

On the following day I made a *post-mortem* examination with the assistance of Mr. Churton. The body was extremely emaciated. Both fore-arms were flexed on the upper-arms, and the hands were clenched and did not admit of being extended. The toes were also drawn downwards towards the soles of the feet, and there was considerable varus on both sides. The lower half of the right cornea was occupied by an ulcer.

The thoracic and abdominal viscera were quite normal. There were no traces of tubercle anywhere present. The spinal cord was also quite normal. The anterior fontanelle was still open. The membranes of the brain were normal. The convolutions on both sides appeared flattened. The ventricles were much dilated and contained about ℥ij of clear serum. Extending from the corpora quadrigemina on the right side nearly to the cerebellum, and occupying the right processus a cerebello ad testes, was a tumour about the size of a large walnut: it encroached somewhat on the left side, and the corpora quadrigemina formed little elevations on its upper surface. The left half of the valve of Vieussens and the left fourth nerve were normal; the right half of the valve formed part of the tumour.

This mass formed a large projection into the fourth ventricle from its floor and right side; the median groove was deflected by it to the right side. The fibres of origin of the right auditory nerve were passed from the groove just below the extremity of the tumour. On looking at the under surface of the brain, the right side of the pons Varolii appeared much more prominent than the left. On making an incision into it the superficial layer of transverse and longitudinal fibres appeared normal, but at the depth of a few lines the substance of the pons was converted into a softish, white, uniform mass, continuous with the tumour. The iter a tertio ad quartum ventriculum was completely obstructed. The following parts were involved in the tumour:—All the deeper parts of the right side of the pons, the right processus ad testes, the corpora quadrigemina to some extent, the right half of the valve of Vieussens, the fibres of origin of the right fourth and fifth nerves.

The substance of the tumour was somewhat softer than the surrounding cerebral matter, from which it was not separated by any line of demarcation: it was of a whitish colour, and closely resembled ordinary white brain-substance. On microscopical examination it presented a network of very delicate nucleated fibres and fibrillæ and many free nuclei,

a very large number of compound granular cells and a few fragments resembling nerve tubes. There were no cells like cancer cells, or any tubercular matter. The tumour was evidently a glioma, that is, a tumour formed essentially by a hypertrophy of the neuroglia, or delicate glue-like connective tissue which exists everywhere between the nervous elements in the brain and cord. It is of the same nature as the so-called hypertrophies and schleroses of the brain, but differs in being partial instead of general. In this case, as in so many others, interference with the origin of the fifth nerve produced ulceration of the corresponding cornea.

Dr. William Cayley, 18*th of April*, 1865.

---

15. *Softening of the entire spinal cord, from a case of general paralysis of the insane, associated with epilepsy.*

The patient, a man, æt. 36, had been for ten years in the Somersetshire County Asylum, subject to epileptic attacks, for which he had been treated (among other remedies, by the extract of belladonna in four-grain doses). Towards the end of life the fits gradually increased. Thus, in 1859, he had seventy-four fits; in 1860, eighty-nine, being eighty-three by day and six by night; in 1863, one hundred and twenty-four, being forty-one by day and eighty-three by night; in 1864, one hundred and sixty-two, being sixty-one by day and one hundred and one by night. He was only confined two days to bed before death, and during that time had several fits.

Post-mortem examination.— Thorax and Abdomen.— The various organs were natural.

Cranium.—The brain was unusually large, weighing fifty-six ounces and a-quarter, the left hemisphere being a quarter of an ounce heavier than the right.

Spinal cord.—This organ was much softened throughout, and was larger than the average size.

Dr. John W. Ogle, 18*th of April*, 1865.

---

16. *General paralysis of the insane.—Epileptic attacks.—Softening of the spinal cord.—Brain unusually firm.*

Frederick R., of middle age, was admitted into the Somerset Lunatic Asylum, Sept. 27th, 1864, suffering under "general paralysis" of the

insane, and remained in the infirmary during the rest of his life, having been troubled at first by diarrhœa. He had a severe epileptic attack on the morning of December the 25th, Christmas-day, and ten fits before the evening; and a succession afterwards until the 27th, when he died.

Post-mortem examination.—Cranium.—The bones of the skull were natural, and the dura mater was easily separable therefrom. The arachnoid membrane was thickened and semi-opalescent. The lateral ventricles were dilated and distended with fluid. The encephalon weighed forty-six ounces and was unusually firm, the entire cerebral structure being somewhat congested.

Spinal column.—The bones were natural, as also the spinal membranes; but the spinal cord was very much softened, especially in the dorsal region.

Thorax.—Both lungs were in a state of pneumonia.

Dr. John W. Ogle, 18*th of April*, 1865.

---

17. *General paralysis and dementia.—Softening of the brain-substance and of the spinal cord.—Pus in the theca vertebralis.*

Flora P., an inn-keeper, æt. 39, was admitted into the Somerset County Asylum, April 23rd, 1864, suffering from "general paralysis," combined with dementia. Her conduct after admission was violent, and she had propensities dangerous to others. Her habits were dirty, and she passed her excreta involuntarily. After the 19th of July she was confined to bed in a helpless but noisy condition, and died on the 14th of August.

Post-mortem examination.—Thorax and Abdomen.—The organs were healthy.

Cranium.—The bones and the dura mater were natural. The arachnoid membrane was slightly opalescent. The brain-substance was very softened, and the lateral ventricles were dilated and distended with serum.

Spinal column.—The bones were natural. On opening the dura mater a quantity of purulent fluid escaped. The spinal cord, which weighed one ounce and a-half, was somewhat softened along its entire length. Dr. John W. Ogle, 18*th of April*, 1865.

---

18. *Thrombosis of cerebral sinuses, with apoplexy of optic thalami, consequent on anæmia.*

Eliza S., æt. 20, admitted into St. Bartholomew's Hospital, under Dr. Jeaffreson, 29th of March, 1865, had enjoyed good health up to twelve months before her death, when, without any apparent cause, the catamenia suddenly ceased, and she began to suffer from anæmia. On admission she was very feeble and anæmic; ancles œdematous; pain in left side; anæmic murmurs in neck, &c. She complained of slight headache, at first frontal, which gradually became more intense, so that on the night of April 3rd it kept her awake. On April 4th she vomited several times, was delirious during the night, and on the 5th became gradually insensible and comatose, the pulse varying from ninety to one hundred and twenty, and being slightly irregular. She died at half-past ten on the morning of the 6th.

Post-mortem examination, twenty-six hours after death.—Brain.—Convolutions somewhat flattened, particularly on the right side, and marked by impress of fibres of dura mater. In the white matter of the posterior part of each hemisphere, about half-an-inch from the upper surface, is a dark clot the size of a pea.

Both lateral ventricles contain a considerable quantity of blood-stained fluid; in the right one is a long, thin, dark clot laid upon the surface of the corpus striatum and optic thalamus. The septum lucidum is entire, but soft. The optic thalami are unusually prominent; on section, they are œdematous and filled with numerous firm, dark clots, by which their tissue, greatly softened, is broken down. These characters are more marked in the right than in the left; but the left corpus striatum presents numerous dark-red points, apparently small clots. The veins of the choroid plexus and velum interpositum, together with the venæ Galeni are distended by firm, partly yellow, and fibrinous clots. These extend continuously along the straight sinus, and for about one inch into the commencement of the lateral sinuses, a little further down the right than the left; but in the lateral sinuses they do not entirely fill the vessels, whilst the straight sinus and the smaller veins are greatly distended by them. The oldest portion of the clot appears to be at the junction of the straight with the lateral sinuses. It is here of a dull pinkish tint, and somewhat soft. The blood in the other sinuses is almost entirely fluid. No disease in any of the cerebral arteries

was detected. The substance of the brain was throughout a little soft and watery.

No tubercle was detected in any organ. Several of the branches of the pulmonary artery in each lung were obstructed by old clots, some of which were breaking down in their centres. There were numerous large ecchymoses immediately beneath the endocardium of the left ventricle, which was very firmly contracted, and in the jejunum there were three recent intussusceptions.

Dr. Andrew, 18*th of April*, 1865.

---

19. *Cerebro-spinal meningitis.*

Clara L., æt. 16, admitted into St. Bartholomew's Hospital, under Dr. Martin, April 13th, 1865.

History.—Was quite well up to April 10th; on that day about eleven o'clock in the morning, was obliged to leave her work at a sewing machine, in consequence of headache and sickness, but was still able to walk home, though with difficulty, from Hoxton to St. Pancras Square, near King's Cross. According to the statement of her sisters she complained in the course of the day of feeling cold; towards evening vomited frequently, and the next day, the 10th, became violently delirious, so that they had some trouble in keeping her in bed. The sickness ceased on the morning of the 11th; the delirium continued. She was the youngest of five children, the other four all healthy. No history of exposure to any infection could be obtained, but she had been greatly heated and fatigued on the 9th. No detailed note was taken on the day of admission, but her general condition and decubitus were then apparently the same as on the following morning. The temperature in the axilla was 103° F., pulse 105 small. The bowels acted twice within an hour of admission, the motions scanty, dark, and powdery. She answered questions readily and sensibly, but had completely forgotten all that had occurred between her reaching home on the 10th and her arrival in the ward, not knowing where she was, or remembering even her being brought to the Hospital.

April 14th.—A well-nourished girl, of fair complexion, frequently changing her position in the bed, but being generally about two-thirds turned over toward the left, with the head drawn backwards as far as possible between the shoulders, the back also being slightly arched. Her friends first noticed this peculiar posture on the 12th. The head

retains this position during sleep, but during the act of deglutition is brought somewhat forwards. She is unable to remain for any length of time on her back, on account of the increase of pain which any strain upon the muscles at the back of the neck occasions. She occasionally wanders, talking incoherently; complains of continual pain at the nape of the neck and of intermitting pain in the head. There is no tenderness over the spinal column, but slight over the abdomen.

Face flushed, eyes slightly suffused, with moderately dilated pupils, both equally so. Respiration hurried, shallow, interrupted by a slight, dry cough. Lips dry and peeling. Tongue dry and thickly coated with yellowish brown fur. Has taken milk, beef-tea, &c., readily, and with ease. Bowels have acted once in the course of the night; motion relaxed; has passed a fair quantity of urine voluntarily; slept quietly, not wandering or talking. Heart and respiratory sounds natural.

April 15th.—On Saturday, decubitus the same as yesterday; still complains of the pain. Bowels acted twice; motions relaxed, of a bright yellow, and slimy appearance (had taken a grain of calomel the previous evening); is thirsty; swallows easily. Skin hot, pulse 96, of greater volume. Catamenia appeared early this morning (she expected their return in the course of this week). Passed a very bad night, screaming continually till about 5 A.M., when she dozed for a short time, and has since been less violent. About 3 P.M. the respiration became embarrassed and noisy; she could still swallow easily; the feet cold; the face gradually more and more livid. A few minutes after 6 P.M. she was attacked by slight convulsive movements, most marked in the muscles of the face, which lasted up to her death, at 6.50 P.M. The face became of a livid purple. She retained consciousness almost up to the setting in of the convulsions, requesting that her father might be sent for, and giving his correct address to the sister of the ward. The sphincters retained their power to the last. The most careful examination failed to detect any rash during the time she was under observation.

Post-mortem examination, forty hours after death.—Rigor mortis well marked. The thumbs slightly flexed upon the palms. Muscles of back natural. Scalp congested and œdematous.

The sheath of the cord contains apparently about the usual quantity of fluid, but what there is is milky and opaque. The membranes of the upper portion of the cord are greatly congested. At the level of the foramen magnum is a little greyish transparent lymph on the posterior aspect, and there are numerous delicate adhesions in the spinal arach-

noid in the upper cervical region. The cerebral convolutions are slightly flattened in the right hemisphere—about its centre a considerable tract of the white matter presents a yellowish tinge. The septum lucidum and pillars of the fornix are soft but entire. The vessels of the choroid plexus and velum interpositum greatly congested. The walls of the ventricles appear natural, and they contain about the usual quantity of clear fluid. There is some slight opacity of the arachnoid at the base. No tubercle detected anywhere, except perhaps in a gland by the side of the trachea, which contains a putty-like mass. The spleen weighed five ounces and a-half, was pale and soft, almost pulpy. Liver and kidneys greatly congested. Supra-renal capsules natural. No change in Peyer's patches: in the right ovary, there was a small recent clot, and also in the interior of the uterus.

Dr. ANDREW, 18*th of April*, 1865.

---

20. *Cases of cerebro-spinal meningitis observed in the epidemic of Dantzig.*

Bertha R., æt. 3 years, previously healthy, was taken ill, 26th of March, with headache, pain in the neck, flushing of the face, and excessive vomiting. When first seen by Dr. Friedländer she was already in a state of stupor, lying on her side with the head thrown back and the legs drawn up. Whenever she was placed in any other position she uttered cries of agony. She remained in the same condition until I saw her on the 11th of April.

At first ice was applied to the nape, blisters were applied to the ears, and calomel was given in repeated doses, the purgative action of which was promoted by injections. During the second week iodide of potassium was given with decoction of bark.

State when examined.—Skin pale and flaccid, no eruption, temperature 100°, pulse 152, respirations 48, difficult and oppressed. On lifting her in bed the child uttered inarticulate, pitiful cries of pain, and her countenance became distorted. There were no such cries when the vertebræ were pressed upon, nor was any tenderness evinced anywhere. When the patient was lifted the head remained fixed in its original position. Pupils neither dilated nor contracted; the right absolutely insensible to light, the left very slightly. There was marked internal strabismus, and both eyes remained open and have a fixed, lustreless expression. On the day after I saw the child again. Dyspnœa

had increased, and there was an eruption of sudamina. She could not take food, and was evidently sinking. She died on the following morning.

Post-mortem examination.—Spinal cord.—On exposing the spinal cord, by slitting up the sheath posteriorly, it was found that the vessels of the pia mater were distended, and the arachnoid surfaces, both visceral and parietal, coloured by minute injection. The visceral arachnoid was lined by a layer of concrete, purulent exudation, which extended without interruption from the cervical swelling to the cauda equina, and completely concealed the cord, while the sub-arachnoid space was occupied by purulent fluid. On the anterior aspect of the cord the exudation occurred only in patches. Above the cervical swelling there was no exudation whatever. On exposing the brain the convolutions were found to be much flattened and their surfaces dry. Concrete exudation of the same character and consistence as that found on the surface of the cord occupied the intergyral spaces over the sulci, especially in the neighbourhood of the longitudinal sinus and around the veins which converge towards the Sylvian fissure. The base of the brain was covered with a thick layer of remarkably firm consistence, which extended forwards to the chiasma, backwards to the anterior surface of the medulla, laterally into the Sylvian fissures and over the inferior surface of the cerebellum, on the surface of which organ it terminated abruptly by a line parallel with its margins. The brain substance was soaked and apparently anæmic, but exhibited no circumscribed softenings.

All the thoracic and abdominal organs were examined and found healthy, excepting that both lungs (especially the right) were airless, and hyperæmic at the bases.

C. S., porter in a bank, was admitted into the Marien Hospital, Dantzig, on the 6th of April. He had been taken ill the day before with shivering, followed by headache and vomiting, and was brought to the Hospital in a state of insensibility. During the night following his admission he was delirious; the delirium continued for a day or two, after which it gradually subsided into quiet wandering. I saw him with Dr. Hildebrandt on the 11th, *i.e.*, the sixth day of his illness, when his condition was as follows:—

April 11th.—When asked questions he answered correctly, but during the visit began to wander and talk, as if to an imaginary third person. In the night he had wandered constantly, but had not been

violently delirious. The pulse was of natural strength and frequency (76) and the breathing was also natural. On lifting him in bed it was observed that the head, which was unnaturally retracted, remained in the same position, and the muscles of the back of the neck felt somewhat stiff, but by no means tetanically contracted. He urgently begged to be let down again; but did not appear to suffer so much as usually observed. An eruption of herpes was just appearing on the nose and lips.

On the following day his condition was much the same, but the pulse had increased to 96; the breathing was also more frequent and laborious.

On the 14th the pulse had again risen to 120. The breathing was laborious and frequent (48). The countenance was flushed and purplish; the nostrils dilated; the scaleni and pectorales contracted strongly on each inspiration, while the larynx sank.

There was dulness of the base of both lungs extending upwards to the spine of the scapula, and harsh bronchial breathing was heard on both sides, with coarse mucous râles. S— could still answer correctly at times, but usually incoherently. He constantly fidgetted with the bed-clothes, &c. Pupils acted well. When he was lifted up the head remained rigid as before. No stool since yesterday. Temperature in axilla, 101.8°. Urine passed naturally.

On the 15th S— was worse. He was less easily roused, and the pupils scarcely reacted. Temperature 101.4°. Skin bedewed with perspiration; pulse 116; respirations 48. There had been no stool for two days. As he had passed no urine naturally, and the bladder appeared distended, the catheter was used. Mental state as before. No attempt was made to raise him in bed; but the muscles of the nape appeared relaxed. S— died 16th of April, at 10 A.M.

Post-mortem examination.—The condition of the spinal cord was very similar to that already described; but the sub-arachnoid space contained a large quantity of liquid pus, while its concrete lining was thinner. Anteriorly the pia mater was free from exudation. As regards the appearances observed in the brain, the case differed from the preceding in the following respects:—On the convexities the quantity of exudation was less and its consistence was gelatinous; on the base there was scarcely any. On the upper surface of the cerebellum there was a patch of purulent exudation, which was found to extend along the venæ Galeni to the choroid plexuses on each side. The ventricles contained a small quantity of fluid pus, which was most abundant in the

posterior cornua. The substance of the brain and cord was somewhat hyperæmic, but appeared to be of natural firmness.

Dr. J. Burdon Sanderson, *2nd of May*, 1865.

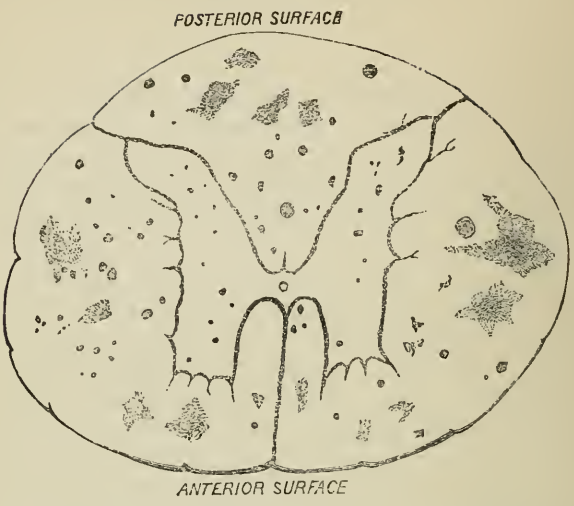
---

21. *On paraplegia after fever.*

This form of paralysis appears to be very common in India amongst men and horses. In a communication which I received from Dr. Macnamara, of Mozufferpore, Bengal, this gentleman makes the following observations:—"This form of disease usually follows fever. It is very peculiar to see in some villages from ten to twenty or more people, both men and boys, affected in this way. Unless very bad, they move on by means of a long pole, the hands and arms being quite unaffected. A man puts the pole out at arms-length, and, leaning on it, drags his legs up to it, and thus manages to get along. Sensation remains perfect, and the bladder is seldom or never affected. It appears to be a simple affection of the motor power of the legs; and so with the horse—it is simply the hind legs that are affected. An animal which I now have, for instance, is perfectly fat and well, and can walk about; but if you press on his back, or attempt to mount him, down he goes, his hind legs bending under him, the fore-legs being as strong and good as ever. Some people who have much to do with horses say that this state of things comes on suddenly, within a few hours, for instance. This statement I do not think is true, though certainly in the human subject one finds that after an attack of fever the weakness is first felt suddenly, and goes on increasing from that time."

Dr. Macnamara informs me that it is rather difficult to obtain a *human* spinal cord, "as these mild Hindoos do not approve of *post-mortems*," but he has sent me the lumbar portion of the cord of a horse which died of this disease. The specimen shows the presence of extensive morbid changes. Both the grey and white substances, but especially the latter, were thickly interspersed with spots and patches of some kind of exudation, and with numerous round, oval, or irregular areas of disintegration, as represented by the dark spots and spaces in the figure (Fig. 8). In some places, particularly in the posterior columns, the exudation was infiltrated over extensive areas into the natural tissue, which it had more or less destroyed. On the nature of this exudation it is not easy to decide. It was not affected either by

Woodcut 8.



æther, acids, or alkalies; but these results were not improbably due to the effects of the spirit in which the cord had for some months been preserved. In cases of ordinary paralysis, in epilepsy, and in tetanus, I have found precisely the same kind of exudation, in either the cord or medulla oblongata, which has been sent to me preserved in chromic acid. Mr. J. Lockhart Clark, 16*th of May*, 1865.

---

22. *Paraplegia, commencing with symptoms thought to be those of sciatica. Caries of the lumbar vertebræ. Effused fibrin external to the spinal dura mater. Corresponding pressure upon, and slight softening of, the spinal cord.*

Cornelius V., of middle age, who was ruptured on the right side about one year before death, experienced pain down the course of the anterior crural nerve, for which he kept quiet for a few days. He found that he could not continue his work, and in a short time severe pain came on in the course of the sciatic nerve on the same side, and the case was treated as one of sciatica—the only means from which he obtained relief being sub-cutaneous injections of morphia. In the course of a little

time he began to experience loss of power in both the lower limbs, and about three months before death the loss of power in these limbs was complete; the sensibility of the skin of the limbs remaining, however, entire, and the sense of pain in them being very acute. Throughout his illness the cerebral functions appeared to be unimpaired. He gradually sank and died, having violent involuntary grinding of the teeth for three or four weeks before death. At no time was there any tenderness or pain on pressure over any part of the spine.

On *post-mortem* examination the body was found to be very emaciated. The spinal column alone was examined, as the friends objected to any other part of the body being interfered with. The spinous processes of the lumbar vertebræ were found to be of somewhat unusual length, and on sawing through the laminæ of these vertebræ they proved to be very soft. On further examination the bodies of the lumbar vertebræ (especially the first and the second) were found to be carious, and the dura mater covering the cord, correspondently to all the lumbar vertebræ, was very adherent to the walls of the spinal canal by means of effused lymph, which, for the distance of one inch opposite the second lumbar vertebræ, was quite organized. The spinal cord in the lumbar region was somewhat diminished in consistency.

For the opportunity of exhibiting the specimens connected with this case, Dr. Ogle had to thank J. Ewens, Esq., of Milton Abbass. He brought it before the notice of the Society at the present time with special reference to the late melancholy death of the Czarewitch, whose fatal illness from inflammation of the membranes of the brain and spinal cord, in connection with caries of the lumbar vertebræ and psoas abscess, had excited much interest, and whose illness had been considered to be, and treated as, lumbago. He also adduced, in connection with this case, one of abscess in the rectus femoris muscle, which had given rise to symptoms which, until the day before death, were thought to be those of sciatica; this case will be found detailed in another part of this volume of *Transactions*.

Dr. John W. Ogle, 16*th of May*, 1865.

---

23. *Encephalocele of the posterior part of the skull.*

This case occurred in the practice of Mr. Taylor, of Guildford.

Mrs. Q., æt. 35, a gardener's wife, mother of five children, none of whom exhibited any kind of malformation, was delivered, the 12th of March, at 6, A.M., of a female child, at the full period. The liquor amnii

was discharged on the evening of the 9th, and labour commenced on the night of the 11th. The presentation was the face, with the chin directed forwards, and the labour was terminated without any difficulty. The child was well grown and plump; its face resembled that of an acephalous monster, both the frontal and parietal bones being flattened so as to leave no forehead and a very small cranium, while from the back of the head there depended a long bag or tumour covered by the scalp, and containing fluid and some substance of soft consistence (Fig. 9). The child was very feeble; breathed badly and with a moaning

Woodcut 9.

noise; it moved its arms, but was not seen to move its legs; it could not suck, though its jaws closed on the finger introduced into its mouth. Some milk poured into its mouth was not swallowed. It became weaker during the day and could not be kept warm. It died the next day at 11 A.M.

After death the bag at the back of the head was laid open in its entire length, when about eight ounces of dark, bloody serum escaped, part of which came from one of the lateral ventricles. The brain came into view, consisting of two hemispheres expanded by serous fluid into thin sacs of a deep-red colour. The bones of the cranium being divided

by a T-shaped cut, the occipital bone was found deficient in all its cranial portions, so that there was a large breach in the skull, through which the brain had escaped into the tumour. The cranial cavity contained only the anterior lobes of the brain, its convolutions elongated and stretched by the dragging of the larger mass contained in the bag. The tentorium was divided and the brain removed, when no trace of a cerebellum could be found. The spinal cord was small and flaccid, and formed no expansion into medulla oblongata or pons Varolii, passing at once into the crura cerebri.

The cranial nerves were extremely small, and appeared to consist of little more than neurilemma, probably from their being put on the stretch. Dr. Murchison *for* Dr. Henry G. Wright, *16th of May*, 1865.

II.—DISEASES ETC., OF THE ORGANS OF RESPIRATION.

1. *Necrosis of the cricoid cartilage, with incipient ossification, in the case of a man, æt.* 30.

The specimen, taken from a young man who died of phthisis, illustrated the pathological changes that precede death of the cartilage. The disease was not far advanced, but the perichondrium had separated entirely from the posterior half of the cartilage on the right side, and was only attached here and there on the left side. When the larynx was opened the cartilage was found to be bathed in pus; and it was to be observed that at several places the cartilage had undergone ossification. Dr. Morell Mackenzie, *15th of November*, 1864.

---

2. *Congenital aphonia. Excresences in the larynx. Deceptive sensation on introduction of the finger into the larynx during life.*

The patient, a child, æt. between 3 and 4 years, could not be examined with the larnygoscope, principally on account of the shape and position of the epiglottis. The case was a very interesting one, as the aphonia had been congenital, or had occurred immediately after birth. The mother had never known the child to utter a sound. When it cried tears came into its eyes, but it could not produce a sound. On introducing the finger into the larynx during life a hard round tumour was

felt beneath the epiglottis. It seemed of cartilaginous or bony character, and was believed to be a growth connected with the thyroid cartilage. There seemed to be no doubt as to the nature of the case, and the patient had been exhibited at another Society, where several Hospital physicians and surgeons carefully examined the larynx and agreed as to the nature of the disease. The child died in an epileptic fit. Instead of a cartilaginous tumour, warty growths were discovered in the larynx. Some small warts, the largest of which was about the size of a tare, were found on the left vocal cord; and beneath the vocal cords on each side the mucous membrane was of a warty or granular character. It became interesting to ascertain how the mistake in diagnosis had arisen.

This, Dr. Mackenzie said, had no doubt been caused by the hyoid bone being pressed down when the finger was introduced into the mouth and felt through the epiglottis. He said, though such cases were rare, and though the mistake could only happen before the cornua of the hyoid bone were developed, he thought the case instructive in a practical point of view, more especially as attention had never been called to this source of fallacy.

Dr. Morell Mackenzie, 15*th of November*, 1864.

---

3. *Two cases of laryngeal excrescence in very young children, in which the growths were removed by forceps, with the aid of the laryngoscope.*

Two little children were brought before the Society by Dr. Morell Mackenzie, and were examined with the laryngoscope by several of the members. The first case was a child, æt. 4, who for two years had suffered from loss of voice, stridulous breathing, and occasional attacks of threatened suffocation. On examining the patient with the laryngoscope, an oblong tumour, about half-an-inch long and a quarter-of-an-inch wide, was seen to be attached just above the anterior insertion of the vocal cords. After a consultation with Mr. Mason, who also examined the case with the laryngoscope, Dr. Mackenzie removed the growth with his laryngeal forceps. After this growth had been taken away, numerous excrescences were seen below, and some of these had since been removed. The base of the growth could still be seen. In this case the respiration had become easy, but the voice was still suppressed.

In the second case, that of a child, æt. 6, there had been also

loss of voice for two years. The patient had been under the care of several medical men, and among others, under that of Dr. Martyn, of Knightsbridge, who used the laryngoscope and recognized the nature of the disease. Finding numerous excrescences on the true and false cords, before operating Dr. Mackenzie had a consultation with Mr. Mason. Since the growths had been removed the voice had become loud and distinctly phonetic, though it was still a little hoarse.

He had brought these cases before the Society whilst they were still under treatment, as the bases of the tumours could still be seen, and as he wished to show with what facility operations on the larynx could be performed. These were the youngest children from whom excrescences had been removed either in this country or abroad. The fragments in each case were exhibited, and also drawings showing their previous position in the larynx. Dr. Mackenzie also showed the forceps with which the growths had been removed.

Mr. Mason said he could corroborate Dr. Mackenzie's statements, as he had examined the children with the laryngoscope both before and after the operations.

Dr. Morell Mackenzie, 20*th of December*, 1864.

---

4. *A case of cirrhosis of the lung.*

The clinical history of this case was as follows:—

Richard B., æt. 34, was admitted into the clinical ward of Guy's Hospital, October 26th, 1864, and placed under the care of Dr. Barlow. He stated that he had no fixed residence, but that he had worked as a labourer on the railroad, docks, &c. He was unable to give any family history, excepting that he believed his mother had died of dropsy. He proceeded to say that when about twelve years he had left home and gone to sea; that he had been intemperate, and drank freely of beer and of spirits. Nine years ago he was in St. Thomas's Hospital for five or six weeks with "spitting of blood." Since that time he had been at work as usual until three weeks ago, when he was obliged to give up his work on account of sharp pain over the region of the liver and between the shoulders.

He thought he had never suffered from rheumatism. He was a strong, powerful-looking man, with well-developed chest and good-sized bones; and although he said that he was now thinner than he had been some time since, yet it was easily seen that he had been a very muscu-

lar man. His skin was moist, not particularly hot, and spots of purpura were noticed on his arms. His face and lips were bluish, and became very livid while coughing. Tongue was white and furred; a red line on the gums. On the cheeks and on other parts of the face one or more small spots were noticed, varying in size from a pea to a fourpenny-piece, which were perfectly white and colourless, and had irregularly defined margins.

Pulse 72, full and regular; respirations 32. He continued to lie most easily on his left side. On examining the heart a systolic bruit was heard, and it was heard loudest about one inch and a-half below, and to the right of, the left nipple—not heard in the course of the aorta, nor in the axilla, but distinctly over and as low down as the level of the ensiform cartilage. In other words, this bruit was heard with the greatest intensity a little to the left of the left margin of the sternum, and midway between what would be considered to be the normal position of the right and of the left apex of the heart. Percussion showed dulness on the left side anteriorly and posteriorly, and there was crepitation at the apex of the left lung. Expiration prolonged. Cough troublesome. Expectoration was purulent and tenacious, with blood in it.

Abdomen distended, and increased dulness over the region of the liver, where there was pain on pressure and on inspiration. No sickness; bowels regular; appetite good; urine was acid, with no deposit of lithates, and no trace of albumen.

When admitted there was œdema over the insteps, but this had got less since the patient came into the Hospital.

October 28*th.*—Tongue cleaner. Pulse 72, and regular. Right side of the thorax and abdomen rounded; the superficial veins were very evident, and more so on the right, than on the left side. Urine clear and scanty.

29*th.*—Pulse 100. Respirations 26. Bowels open.

November 1*st.*—Pulse 80. Tongue clean. Stethoscopic signs the same.

2*nd.*—Patient up and dressed to-day. The systolic murmur heard in the same place as on admission. Crepitant râles under the left clavicle, with marked dulness on percussion.

3*rd.*—Expectoration purulent and mixed with blood. Urine high coloured, but no albumen detected.

4*th.*—Said that he felt better. Pulse 88. Feet and legs œdematous after being out of bed a few hours.

DESCRIPTION OF PLATE III.

Illustrating Dr. Barlow's and Dr. H. G. Sutton's case of Cirrhosis of the Lung (p. 39).

Fig. I.—Section from that part of the lung most adjacent to the thickened pleura. In one part of the field the diseased pleura is seen to be made up of fibroid cellular elements; well developed bundles of newly formed fibrillated tissue, and between the bundles round and elongated cells with granular contents.

A. Represents a bundle of newly formed fibrillated tissue (the artist has drawn the delicate fibres too distinctly).

B. A number of spindle-shaped cells, associated with spherical, oblong, and other granular corpuscles.

C. A quantity of elastic tissue, being the normal elastic tissue of the cell-walls, but the bundle so large that in all probability it consists of the elastic fibres of two or three air-cells thrown into this shape by the atrophy and welding together of the cells.

D. The remains of an air-cell.

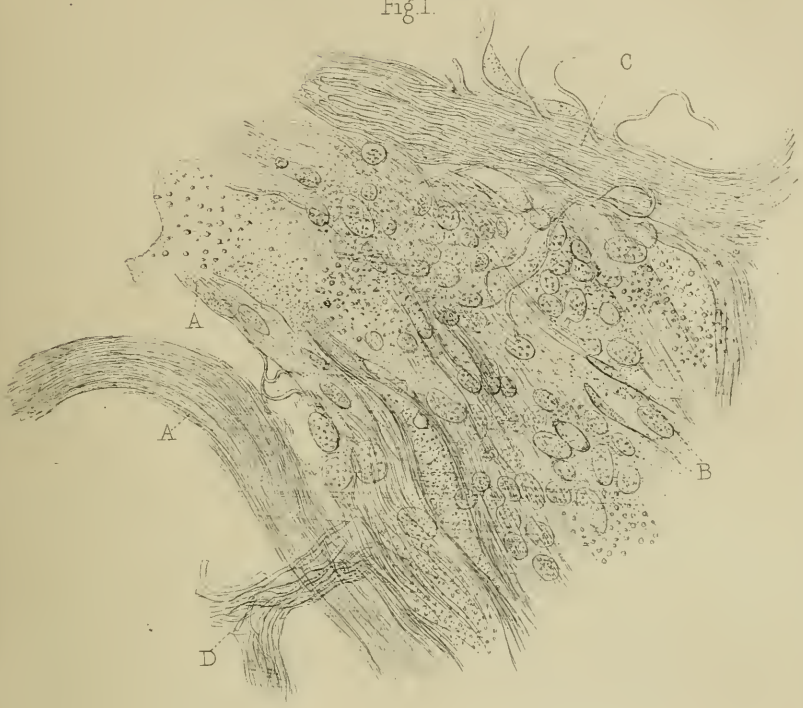
Fig. II.—A thin section from the middle of the upper third of the lung showing the walls of the air-cells, and the air-sacs filled with newly formed tissue elements.

A. A number of granular corpuscles, of various shapes, but having no very visible nuclei.

B. A mass of fusiform, spherical, and other shaped cells, and ovoid granular corpuscles between the fusiform cells, indicating growing fibroid tissue.

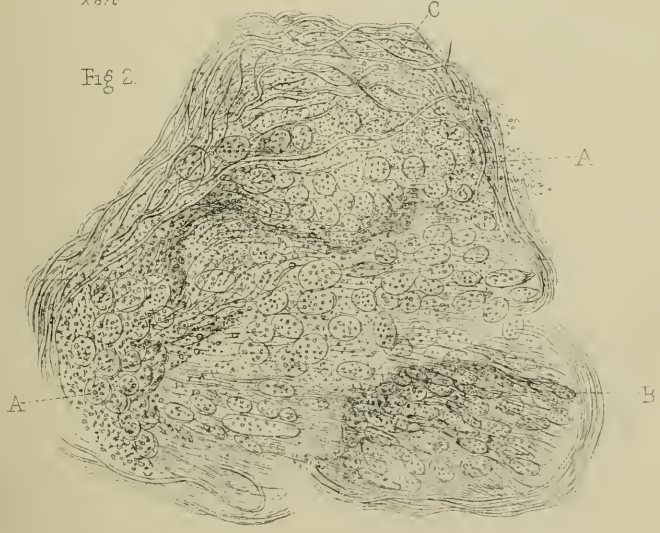
C. Elastic fibres of the air-sacs.

Fig 1.



×870

Fig 2.



8*th.*—Much the same.

14*th.*—Pulse 100. Bruit heard as before. Crepitation and dulness at the left apex, and percussion indicated that the liver was enlarged.

23*rd.*—Bruit still heard in the same situation; well marked dulness and crepitation were evident over the left apex, both anteriorly and posteriorly. Legs and feet œdematous. Pulse 100. Tongue furred. Complains greatly of difficulty in breathing.

25*th.*—Lividity of the face less when up than when in bed, otherwise he was much in the same condition. Urine discovered, however, to be slightly albuminous. Lithates in abundance. The patient remained in much the same condition until about three days before he died, when he complained of increased difficulty in breathing, and his face became even more markedly livid than it was before. On December 11th, 1864, he died of what appeared to be an attack of capillary bronchitis.

Post-mortem examination by Dr. Wilks, made twenty hours after death. Face bloated and purple, general anasarca moderate in amount. Abdomen distended. Head not examined.

Pleura (left) enormously thickened, the costal universally so, but the pulmonary pleura was natural over a small part of the lower lobe of the lung, where the tissue was, to all appearance, healthy. A circumscribed, keloid-looking patch on the right pleura, thick and puckered, but no effusion.

Bronchi.—The right natural, but the left had its mucous membrane red and thickened; the secondary bronchi and all the smaller branches were shrunken and very red within, but there were no dilatations.

The lungs.—The right, though very large, was quite healthy in texture. The left lung, in its upper part, and in fact all except a portion of the size of a pear at the base posteriorly, was converted into a gristly mass, which on section presented the cut ends of the great vessels and shrivelled tubes, with a great deal of white fibroid tissue. In one or two places a piece of seemingly good lung, of the size of a horse-bean was left, as an islet in the fibrous mass. The part which had escaped induration and appeared healthy was not emphysematous. The bronchial glands were sound.

Heart very large. Left ventricle did not appear to have suffered. The right ventricle was dilated and much thicker than natural, and this was especially true also of the right auricle. The edge of the tricuspid valve was thickened. Liver enlarged; section showed the nutmeg

appearance. Spleen large and very firm. Kidneys much enlarged, coarse, and congested, and a small cyst was found in one kidney. Intestines were normal.

It may be remarked that in this instance we were enabled during life to diagnose a somewhat unusual form of heart disease (disease of the tricuspid valve), and also the exact nature of the lung disease. The former we were led to infer, by way of exclusion. A "bruit" near the apex of the heart at first suggested the idea of diseased mitral valve. This was excluded by the character of the pulse and by the circumstance of the bruit becoming feebler and entirely disappearing as the stethoscope was placed over and nearer the axilla. There remained, then, the question between old pericarditis and tricuspid regurgitation—to the former was opposed the absence of any evidence of previous rheumatism, as well as of any illness that could be construed into pericarditis. The seat of the murmur was also lower and more to the right than is ordinarily the case with a pericardial bruit, whereas the part nearly over the ensiform cartilage was in favour of tricuspid regurgitation. The circumstance of the murmur not being exactly over the ensiform cartilage was probably accounted for by the heart being dragged up by the contraction of the apex of left lung. The nature of the disease of the lung was inferred from the history of the patient, including his habits, from the symptoms generally being opposed to phthisis, (as was also the fact of the heart disease,) and from the white spots on the face, which were supposed to be owing to fibroid change in the skin.

Dr. G. Hilaro Barlow, *3rd of January*, 1865.

Report on the above specimen.—On referring to the diseased lung, it will be noticed that the pleura on the suface of the lung, had been very much thickened; and still closer observation will show that the process of thickening had extended into the surface of the lungs, so that there is no abrupt line of termination between the diseased pleura and the lung, but the reverse: they gradually fade into one another, so much so that it cannot be said where one begins and the other ends.

It will be further noticed that the connective tissue around the bronchial tubes and pulmonary vessels is unusually distinct, and that it is apparently increased in quantity.

With the object of endeavouring to throw some light upon the nature of the pathological changes that had taken place, sections were made from different parts of the lung, and drawing No. 1 represents a

thin section from the lung adjacent to the greatly diseased pleura. (See Plate III.)

Drawing No. 1.

Section from that part of the lung most adjacent to the thickened pleura. In one part of the field the diseased pleura was seen to be made up of fibroid cellular elements; well developed bundles of newly formed fibrillated tissue, and between the bundles round and elongated cells with granular contents.

A. Represents a bundle of newly formed fibrillated tissue.
B. A number of spindle-shaped cells, associated with spherical, oblong, and other granular corpuscles.
C. A quantity of elastic tissue, being the normal elastic tissue of the cell-walls, but the bundle so large that in all probability it consists of the elastic fibres of two or three air-cells, thrown into this shape by the atrophy and welding together of the cell.
D. The remains of an air-cell.

The normal elastic fibres could be easily distinguished from the new fibroid tissue;—by the greater length of each individual elastic fibre, by the readiness with which each fibre could be traced, by the dark outline and bright sparkling centre of the elastic fibre, and lastly by their arrangement and curving.

Thus it will be seen that the pathological process going on in the pleura, had extended into the lung and wholly destroyed the air-cells.

Drawing No. 2.

A thin section from the middle of the upper third of the lung showing the walls of the air cells, and the air sacs filled with newly formed tissue elements.

A. A number of granular corpuscles, of various shapes, but having no very visible nuclei.
B. A mass of fusiform, spherical, and other shaped cells, and ovoid granular corpuscles, between the fusiform cells, indicating growing fibroid tissue.
C. Elastic fibres of the air-sacs.

A third section made from that portion of the lung which appeared comparatively healthy, showed the air sacs to contain a number of granular corpuscules mostly of a spherical form.

The result of the microscopical examination appeared to show :—

1. That there had been a formation of new tissue elements, and of such elements as are usually considered to represent fibroid tissue.
2. That such newly formed tissue elements were most highly developed in those parts of the lung most adjacent to the thickened pleura and the increased fibrous tissue around the bronchial tubes.
3. That the newly formed fibroid cellular tissue could be readily traced, extending into the lung substance from the diseased pleura, and also from the fibrous tissue around the bronchial tube; the portion of the lung most removed from these parts contained only granular corpuscules.

These sections were examined and drawn under an one eighth of an inch with the second eye-piece, magnifying about 870 diameters.

Dr. H. G. Sutton, 17*th of January*, 1865.

---

5. *Chronic ulceration of the Larynx.*

The larynx was taken from a man who had been suffering from laryngitis for upwards of two years, and had been under treatment a long time. There was no evidence of any disease of the lungs, and after death these organs were found healthy, with the exception of some quite recent pneumonia.

When examined with the laryngoscope, extensive deep ulceration was seen around the epiglottis, and below it; but I did not see the vocal cords. There was constant swelling about the tonsils and uvula for some time. Various applications were made to the larynx, but without much benefit. When I performed laryngotomy on the 11th of November, the man was apparently dead; but by dint of Sylvester's method he rallied and lived in comparative comfort five days. There was no history of syphilis, though the man was supposed to have had it. He was a labourer, and had been abroad, but generally had enjoyed good health.

Mr. William Squire *for* Mr. W. D. Spanton, 17*th of January*, 1865.

6. *Patient recovered from necrosis of the cricoid cartilage.*

The case of this patient was brought before the Society on the 3rd of March, 1863, and is published in the fourteenth volume of its *Transactions*, with a woodcut. He continued pretty well up to February, 1864, when the pharynx became extensively ulcerated, the mucous membrane of the larynx swollen, and the breathing rough. In March dysphagia occurred, from the ulceration extending to the pharyngeal surface of the cricoid cartilage, and the patient ate but very little. The larynx, however, was clear, and the vocal cords were seen fairly normal. He subsequently got better, the pharyngeal ulceration healed, and he swallowed well. On the 2nd of August, he stated that he had felt pretty well up to lately; but now there was evidently some obstruction to breathing, arising from considerable swelling of the false cords, associated with stridor and clangous cough. The epiglottis was a little œdematous. I advised tracheotomy at once, and the patient was admitted into the Westminster Hospital, under the joint care of Mr. Holthouse and myself. It was divined beforehand that the rings of the trachea were ossified, and so it proved during the performance of the operation by Mr. Holthouse. This condition added much to the difficulty of the operation, requiring portions of the ossified rings to be regularly cut away with suitable cutting forceps. The relief was immediate and decided, and much mucus was expectorated through the silver tube.

His subsequent progress was most satisfactory, for he went on without a single untoward symptom, and he left the Hospital on the 7th of September comparatively well, wearing the tube, although all evidences of obstruction had subsided. On the 27th of September he called upon me, and spoke in a good, firm, and loud, but a little rough voice, on placing his finger upon the end of the tube. He ate and slept well, but could not lie on his back, a circumstance partly explained by the pendent position of the epiglottis. He resumed his employment at Christmas. Examination with the laryngoscope in January, 1865, showed the subsidence of all swelling; the true vocal cords were normal, the opening through which the necrosed portions of the cricoid cartilage had passed on former occasions was completely cicatrized, and the epiglottis was more erect. His voice continued good, but was a little husky. He wore a good double tube with an oval aperture at the top, which it was desirable not to dispense with in consequence of the inclemency of the weather. He had gained flesh and strength, and had

fully recovered from the condition of necrosis of the larynx which had at one time proved so critical to his life. It was in this satisfactory state that the patient was presented to the Society for inspection, and he was enabled to answer the questions put to him in a tone that was heard by all the fellows present. Dr. Gibb, *7th of February*, 1865.

---

7. *Portions of ossified tracheal rings expelled some months after tracheotomy.*

It became necessary to perform tracheotomy in a gentleman under my care, in April, 1864, for chronic disease of the larynx, with subglottic obstruction. This was done by Mr. Holthouse at my request, and the operation proved one of considerable difficulty, from the almost steel-like hardness of the ossified rings of the trachea, the result of a gouty constitution. With strong bone-nippers only could the requisite opening be made to admit of the insertion of the tube, and when that was accomplished the patient was instantly relieved, and in a few days was up and about again. Some months later, portions of rings exfoliated, loosened, and were expelled, affording much relief to some general discomfort at the time. On examination they presented the characters of compact bony substances, with little or no calcareous material about them. Dr. Gibb, *7th of February*, 1865.

---

8. *Case of diphtheria, with pulmonary apoplexy and intense congestion of the stomach and ileum.*

W. M., æt. 15, was admitted into the Middlesex Hospital, under my care, on the 29th of December, 1864. He had then been suffering from sore throat for six days. His expression was anxious; face rather flushed; skin hot; pulse 94, feeble and compressible. The soft palate was red and tender, the pharynx inflamed, and the tonsils red and swollen; there was a small patch of exudation on the right tonsil, apparently covering a superficial ulcer, and the surrounding surface bled on being accidentally touched with the spatula; the glands at the right angle of the lower jaw were swollen and tender. Two days later the patient was decidedly better, the congestion had nearly disappeared from the soft palate, and he had begun to relish his food. On the night of the 1st of January the patient slept badly, and the following day appeared to be more prostrate. His pulse had then fallen to 72, but was exceed-

ingly weak, and he had vomited several times. The throat was again more inflamed, and there was a patch of exudation on the left tonsil, with swelling of the glands at the corresponding angle of the lower jaw. He lay quiet, and answered questions with reluctance. The urine on this day, for the first time, contained albumen, in the proportion of about a fifth.

On the 3rd of January there was epistaxis and apparently oozing hæmorrhage from the fauces; there was also slight cough, with expectoration of frothy mucus mixed with blood, and vomiting recurred from time to time. Pulse 72, very feeble. The urine contained one fourth of albumen; specific gravity, 1014. There was now evidently ulceration of the left tonsil, and two patches of exudation had appeared upon the posterior wall of the pharynx.

Vomiting continued at intervals, the prostration increased, suppression of urine took place from the morning of the 4th, and the patient died on the morning of the 6th of January.

At the *post-mortem* examination the papillæ of the tongue were very prominent, and the soft palate and pillars of the fauces and the parts at the base of the tongue very œdematous; the mucous membrane of the fauces was intensely red, and on the uvula was a small yellowish-white patch of slightly adherent false membrane. The tonsils were much enlarged, and on the inner aspect of each was an ulcer with a sloughy surface. The tissues surrounding the tonsils were infiltrated and brawny, the tonsils themselves of a brownish-red colour on section, very hard, and sloughy in the centres.

The epiglottis and the aryteno-epiglottidean folds were thickened and very œdematous; the under surface of the epiglottis was covered by a yellowish, slightly adhering patch of false membrane. The mucous membrane covering the vocal cords was normal. The œsophagus appeared normal. The mucous membrane of the trachea was reddened and somewhat rough, especially towards the lower end; that of the larger bronchial tubes was intensely injected. The tubes going to the upper part of the lower lobe of the right lung contained a moderately firm, black coagulum. On both sides beneath the pulmonary pleura there were numerous minute ecchymoses, and also a few similar spots beneath the pericardium at the base of the heart. In the upper part of the right lower lobe, near the posterior surface, was a patch of pulmonary apoplexy as large as a hen's egg, which was sharply bounded off from the rest of the lung; its surface, on section, was of a nearly black colour, and very granular. There was

a similar mass in the upper lobe about the size of a walnut, and two or three smaller ones in the left lower lobe.

The peritoneum was normal; the kidneys were rather large, but quite normal in appearance; the cortices were rather pale; the pyramids congested.

The stomach contained some black, altered blood; the mucous membrane was everywhere injected, and of a dark red colour; the injection was arranged in small patches, and here and there towards the lesser end were small extravasations; the surface was coated with a layer of somewhat viscid mucus, streaked with blood. The mucous membrane throughout the small intestines was reddened, and towards the lower part of the ileum visibly injected, with here and there small ecchymoses in its substance. The solitary glands were somewhat prominent. Peyer's patches appeared normal. The bladder was quite empty and contracted.

Remarks.—This case is chiefly interesting on account of the congested state of the stomach and ileum, and its association with vomiting. This symptom is of not unfrequent occurrence in the more asthenic form of diptheria, in which it sometimes supervenes, when the patient had previously appeared to be going on satisfactorily. It for the most part comes on rather late in the illness, and is always an alarming and often a fatal symptom. In several cases under my care it has occurred, as in the present instance, during the course of the second week, coincidentally with a highly albuminous condition of the urine; and most frequently the glairy mucus, which forms a considerable portion of the vomit, has been streaked with blood.

Dr. Greenhow, *7th of February*, 1865.

---

9. *Case of bronchial casts.*

E. T., æt. 7, a patient of Mr. Fagge's, of Hythe, Kent. She had been suffering for about ten days from a severe cough, which was described as coming on in spasmodic fits, and as being much relieved by expectoration, which consisted chiefly of mucus, but had twice contained about a tea-spoonful of blood. In the intervals she was pretty well, and had walked a distance of two miles the day before Mr. Fagge first visited her. This was on June 21st, 1864. On the evening of that day she expectorated for the first time a cast of the bronchial

tubes. Afterwards one of these casts was ejected at least every day. On the 24th she had a most distressing fit of coughing about 3 A.M., in which her friends thought that she would die. However, she got rid of a cast larger than any of those which had been expectorated up to that time (see Fig. 10), and afterwards she said that she was much

Woodcut 10.

better, walked briskly down-stairs, and had no cough for several hours. Mr. Fagge saw her that afternoon. Her pulse was then quick, and there was considerable dyspnœa. A stridulous râle was audible, especially on the left side of the chest, and her aunt said that she was in the condition which usually preceded an attack of coughing. At 3 P.M. she became much distressed, coughed violently, fought for her breath, became dark in the face, and died.

It ought to be mentioned that pertussis was epidemic at the time; her sister fell ill of that disease shortly afterwards. No case of diphtheria was known to have recently occurred in the neighbourhood. The treatment consisted in the application of mustard poultices, and in the administration of small doses of nitre, antimony, and ipecacuanha wine.

On *post-mortem* examination, the upper portion of the respiratory

passages was found to be healthy; but the lower part of the trachea was occupied by a large fibrinous mass of the same size as that which had been expectorated on the morning of the girl's death. The ramifications of this cast extended into the right bronchus and its branches, but its larger end lay across the bifurcation of the trachea, occluding the entrance of the left bronchus so completely that it appeared at first as if it would occupy the branches of that tube also. This cast is represented in Fig. 11. The air tubes contained no other masses of fibrin;

Woodcut 11.

but the small bronchi in the upper part of the left lung were filled with mucus. The lung tissue on that side was slightly less crepitant than that of the right lung, which was quite healthy.

On minute examination, the casts were found to be composed of a large number of delicate concentric laminæ. These laminæ consisted of a homogeneous membrane, with a tendency to fibrillation, containing numerous small bright rounded particles, smaller than a blood corpuscle, which appeared to myself and Dr. Wilks to be shrivelled nuclei.

The case appears to be of interest, not only on account of the youth of the patient and of the large size of the casts, but also because of the

unusual way in which the disease terminated. It might be expected that suffocation would be a frequent occurrence as a result of the formation of these casts; but this is undoubtedly not the case; and I have not been able to find a single instance of it recorded, either in the Pathological Society's *Transactions* or elsewhere.

Dr. Hilton Fagge, 21*st of February*, 1865.

---

10. *Primary cancer of the left lung and of the mediastinal glands.*

W. G., æt. 31, a lithographic printer, admitted into Victoria Park Hospital, under Dr. Edwards, on the 13th of February, and died on the 16th of February, 1865.

Stated that he had been quite well and strong up to three months before admission, when he began to suffer from cough and dyspnœa; that he had applied at the Hospital in the previous October on account of hoarseness, and he was then thought to be suffering from phthisis; unfortunately the particulars of the physical examination had not been recorded. The following note was taken on admission :—

Poorly nourished; sallow; lips dusky; tongue has thick brown fur on dorsum; no appetite; constant thirst; occasional nausea; slight diarrhœa; cough very troublesome at night; sputa watery and frothy; cannot lie on his right side; respirations 32, diaphragmatic; pulse 120, soft; urine scanty, loaded with pale lithates; chlorides all but absent.

Physical signs.—On left side, from clavicle to mamma, great bulging; absolute dulness; absence of respiratory sounds and vocal vibrations; slight friction sound near mamma, posteriorly; feeble respiration, with a friction sound; on the right side a little crepitation inferiorly.

The heart was displaced downwards and to the right, and there was some enlargement of the subcutaneous veins over the left side of the thorax.

Post-mortem examination.—A large malignant growth occupying the upper lobe of left lung; the mediastinal and bronchial glands enlarged, and the seat of malignant disease. The main bronchus of the upper lobe is completely obstructed, its orifice being plugged by a soft medullary mass. The great vessels arising from the arch of the aorta and the transverse portion of the arch itself pass through and are compressed by the tumour, but are still pervious. The left innominate vein is all but obliterated, the most contracted portion being occupied by

a clot which is firmly adherent to the walls of the vessel, and which appears to have been itself invaded by the disease by direct continuity. The branches of the pulmonary artery supplying the affected lobe are completely obliterated.

Heart.—Recent acute pericarditis. Projecting into the interior of the left auricle from the orifice of the left pulmonary vein, which it completely obstructs, is a small nodulated, button-shaped tumour.

Dr. Andrew, *7th of March*, 1865.

---

11. *Disease of the trachea, probably syphilitic, opening into the aorta.*

Thomas C., æt. 51, was admitted into Guy's Hospital, under Dr. Rees, in February, 1865, with great difficulty of breathing. This was sometimes so severe that he had to gasp for life. The lungs showed no disease on auscultation, nor did the larynx on examination by the laryngoscope. He died at last suddenly after bringing up some blood. It was then thought that an aneurism must have existed. He had never been closely questioned with reference to a history of constitutional syphilis: he had had, however, a local sore and a bubo, the cicatrices of which remained.

On *post-mortem* examination, the larynx and tonsils were healthy. The vocal cords and glottis were also unaffected. Immediately beneath the cords, and as far as the bifurcation, the larynx and trachea were exceedingly diseased, the change being due to a chronic ulceration, thickening, and contraction of the entire air tube. The whole trachea was narrowed, but at its upper part, where it joins the larynx, it was so contracted that the tip of the finger could not be inserted into it. For about the length of two inches the trachea was flattened and its surfaces were in approximation. Upon looking at a section of the tube at this part, it was seen to be flattened from side to side, and its mucous membrane at some spots to touch elevated portions on the other side. The walls of the tube were also much thickened from the new tissue formed beneath the mucous membrane, also from the fibrous tissue which united the rings together, and which had been poured out external to the trachea.

Upon looking at the interior, the surface presented a most irregular and uneven appearance, from the ulceration and cicitrization which had taken place. Beneath the vocal cord there was a deep depression as of a former ulcer; below this a general irregular surface; then, at

the commencement of the trachea, there was the contraction before mentioned, and below this again the trachea became wider, but the mucous membrane was gone and the rings were exposed. Here there was a perforation which admitted an ordinary sized probe and communicated with the aorta. This was nearly an inch above the bifurcation. At the latter place there was a large fibrous cicatrix, the mucous membrane being gone and its place occupied by a patch of tough, fibrous cords, which, interlacing, puckered up the tissue and caused another slight contraction at this part. It also involved the commencement of the two bronchi, the entrances of which were much narrowed in consequence. This cicatriform appearance suggested the syphilitic nature of the disease. The perforation above mentioned passed direct into the aorta at the back part of the arch, and immediately beneath where the large vessels are given off. The hole was round and small, just admitting a probe. The aorta was atheromatous throughout. On examining the tissue between the vessel and trachea, there appeared to be no intervening disease. The passage was direct into the aorta, the perforation being at the bottom of a deep ulcer where the ring of the trachea had been destroyed. The lungs were full of blood. The other organs healthy.

Dr. Samuel Wilks, *7th of March*, 1865.

---

12. *Primary epithelial cancer of the epiglottis and pharynx, involving the vocal cords.*

The subject of this disease was a man upwards of 60 years of age, who had attended St. Mary's Hospital, as an out-patient, under Dr. Sieveking.

When first applying, January 10th, 1865, he complained of a continuous harsh cough, and considerable difficulty of respiration after the slightest exertion. The pulmonary sounds were normal, and the symptoms seemed entirely referrible to the throat.

The laryngoscope alone could further the diagnosis of this case, and by its aid a tumour was discovered upon the left side of the epiglottis; but difficulty was experienced in obtaining a view of the passage of the larynx, which was occupied by a considerable quantity of mucopurulent sputa, so as entirely to prevent the true cords from being distinguished. From this time the symptoms became rapidly aggravated, the secretion of sputa constant, the cough severe and exhausting, res-

piration hoarse, whistling, and prolonged, and, according to the account of the patient, often accompanied by paroxysms of urgent dyspnœa.

No malignant disease, or appearance of such, could be detected in any other part of the body, so that from the laryngoscopic examination, together with the above symptoms, and the consequent rapid emaciation and exhaustion, it seemed clear that primary cancer existed in the larynx. The patient gradually sank and died on March 18th, 1865, about six months after the commencement of the laryngeal symptoms.

At the *post-mortem* examination, a morbid growth of epithelial cancer was found projecting from the posterior or under surface of the epiglottis, along its left third, extending upwards to within a quarter of an inch of the tip of the epiglottis, downwards to the posterior angle formed by the vocal cords, and laterally along the wall of the pharynx to the extent of an inch and a quarter (*see* Plate IV.). This growth had prevented the vocal cords being seen during life. It presented an ulcerated surface, and was hollowed out into a large cavity in the wall of the pharynx, to the left of the epiglottis, and passing downwards to the left of the larynx. The left aryteno-epiglottidean fold was entirely destroyed, and the growth involved the left false cord at its posterior angle, a small mass at this part, about the size of a pea, being seen from below, projecting through the rima glottidis. The true cords and the larynx below them were intact.

A fine section placed beneath the microscope exhibited but a small amount of fibrous structure. The substance consisted almost entirely of cells with barely sufficient areolar tissue to hold them in position, thus, perhaps, explaining the immoderate tendency to disintegration. The cells were of irregular and variable form, many enclosing more than one nucleus (*see* Plate IV.).

Mr. A. T. Norton, *4th of April*, 1865.

---

13. *Primary cancer of the larynx, destroying the epiglottis, as seen with the laryngoscope.*

A naval officer, æt. 60, who had been ill for fifteen months with extreme irritation of his upper air passages. I first saw him with Mr. H. Taynton, of the Commercial Road. His lungs were sound, but there was a constant hacking cough, with a great deal of expectoration, a choking sensation, and at times dysphagia, with fluids. He passed sleepless nights, his appetite was bad, and he had fallen away

DESCRIPTION OF PLATE IV.

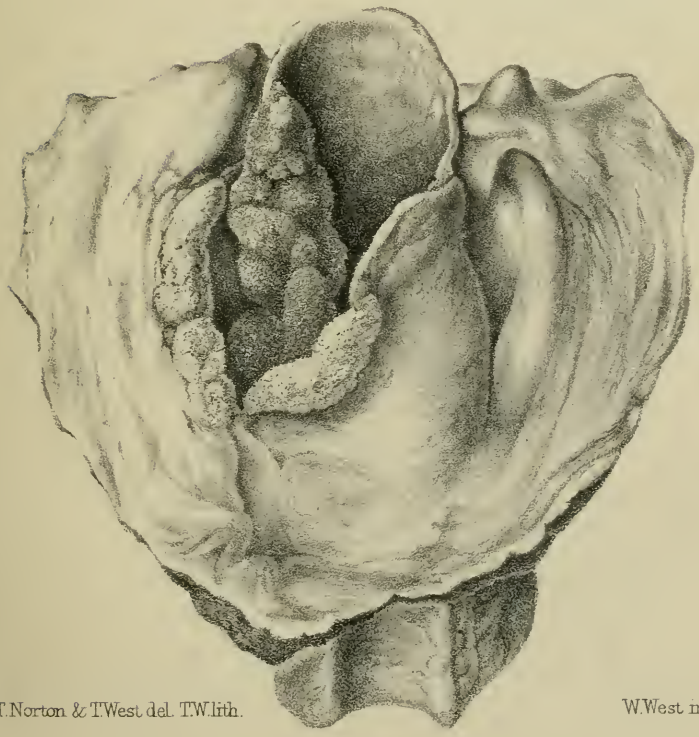
Illustrating Mr. A. T. Norton's case of Primary Epithelial Cancer of the Epiglottis and Pharynx, involving the Vocal Cords (p. 53).

Fig 1 shows the microscopic structure of the growth which was composed mainly of nucleated cells with a small amount of areolar tissue.

Fig. 2 shows the situation and appearance of the growth, natural size.

Fig. 1.

Fig. 2.



and got worse during the previous week; nevertheless, his general health was good, and his voice clear and distinct, though a little tremulous. On the left side an enlarged submaxillary gland, the size of a walnut, had been noticed for twelve months. On introducing the laryngoscope the fauces were seen to be normal. The epiglottis was wholly destroyed by ulceration and reduced to a mere stump, a single large granulation occupying its middle line. The true vocal cords were indistinctly seen during the utterance of sounds; the right false cord was red and fleshy and a little swollen, whilst the left was irregularly swollen, ulcerated, and covered with granulations. The chief amount of disease was present in the left aryteno-epiglottidean fold and false cord, the whole presenting a raw, ulcerated surface, with several granulations projecting towards the interior of the larynx. The arytenoid cartilages were not distinctly visible, from the tumefaction of the surrounding mucous membrane, and there was free secretion of mucus.

There could be no doubt as to the nature of the disease being malignant, and it was freely touched with a solution of the iodide of silver, while the iodide of sodium, combined with other substances, was ordered internally.

He certainly improved under the use of these remedies, so that the cough and secretion became less, and he could swallow fluids without any difficulty. He slept better, was not so pale and wan, and the general ulceration was diminished. Somewhat later, the submaxillary glands and the parotid of the left side commenced to enlarge, and became hard and painful: the ulceration of the larynx had a more unhealthy look. In the latter end of August the tumour of the neck was found to be increasing, and at times very painful. The throat was easy, but the left side of the larynx formed a prominent growth, which appeared as if extending to the pharynx, and could be seen with the naked eye at the back of the mouth, without the aid of the laryngoscope. The disease now extended to the interior of the larynx, attacked the left true vocal cord, and aphonia ensued. The parotid swelling now increased, with great pain, and the left side of the neck became also greatly swollen from œdematous infiltration of the subcutaneous structures, and enlargement of the glands of the neck on that side. The infiltration partook of the well known brawny character of malignant disease, and by the middle of October two fluctuating swellings had formed in the neck, which were opened, and pus was evacuated. He was able to swallow tolerably well almost up to his death on the 4th of December, having

been confined to his bed only five days. He was sensible, and breathed well, and swallowed fluids; his voice even improved, and he died quietly from exhaustion and want of food. The parotid tumour had become very large, and spread upwards to the ear: it was very painful.

Permission was granted to examine the diseased parts only, and medullary sarcoma was found to have extended through the thyro-hyoid membrane, destroying the left true vocal cord and the parts on the left side of the larynx, but not involving the tongue, which was quite healthy at its root.

In this case the cancerous disease was clearly primary, first attacking the epiglottis, the whole of which was destroyed, and subsequently affecting the glands on the left side of the neck. Deglutition was comparatively good throughout, with but little or no pain, and the voice was good until the left vocal cord was involved.

In a conversation with Mr. Oliver Pemberton, of Birmingham, at Cambridge, in August, 1864, he told me he had never seen a well authenticated case of primary cancer of the larynx. The fact is now, however, undisputed that such does really exist, and many examples, clear, well marked, and unmistakeable, have come under my notice.

In the thirteenth volume of *Trans. Path. Soc.*, is the record of an instance of epithelial cancer of the left side of the interior of the larynx, communicating with an abscess in the neck, causing aphonia, which was undoubtedly primary. I exhibited the specimen for Dr. M^c^Oscar.

Another instance, equally clear to my mind, appears in the twelfth volume of *Trans. Path. Soc.*, of cancerous tumour, involving the larynx and dislocating the epiglottis and hyoid bone, in which death ensued from sudden spasm. It occurred in the practice of Dr. William Tindall Robertson, of Nottingham, and, in conjunction with Dr. Dickinson, I prepared a report on the specimen, after careful examination.

Louis has recorded an example of primary cancer of the larynx, which is noticed in Dr. Walshe's work on *Cancer*.

There is a specimen in the Museum of the London Hospital, of cancer affecting the larynx from the vocal cords downwards; another in the Museum of St. Mary's, of cancer confined to the larynx from a patient who had been under Dr. Alderson's care. A third exists in St. Bartholomew's, of a cancerous tumour springing from the left wing of the thyroid cartilage, not unlike Dr. Robertson's case. Indeed, many others might be cited, but it will be sufficient to refer to the

well-marked instance brought before the Society, at its last meeting, by Mr. Norton, and the example brought before the Society by myself, in May, 1864 (vol. xv., p. 54), of a cancerous growth of the larynx partly removed through the mouth and partly through the pomum Adami. Besides all these, I have three cases under my care at the present time, which are undoubted instances of primary laryngeal cancer; and my object in thus strongly drawing attention to the subject, is the importance of clearness of diagnosis, for the purposes of treatment, especially in its early stage. Although admitted to be comparatively rare by those who do not deny the existence of the idiopathic laryngeal affection, we must not be unprepared to meet and deal with it when it does occur, for it is at all times a grave and serious malady. Dr. Gibb, 18*th of April*, 1865.

---

14. *Cornish miner's lungs.*

The specimen was removed from the body of a man, æt. 55, who had been of somewhat irregular habits, and had worked in different tin and copper mines in Cornwall for about thirty-eight years. He had begun to work underground when he was thirteen or fourteen years of age, and had been compelled to give up working two years before his death. He had been ailing for about five years, and had complained of pain in the right side of the chest which prevented his lying on that side, of difficulty of breathing, and of cough and expectoration. He had spat some blood, and was considerably emaciated. The left lung was firmly adherent to the parietes by old and thick false membranes, and the substance of the lung was sparingly crepitant, emphysematous at the edges, and of a deep blue or black colour. The bronchial tubes contained a brown-coloured, muco-purulent fluid. The right lung was also firmly attached by thick, fibro-cartilaginous adhesions. It was throughout considerably solidified, especially at the upper part, and at the apex there were several irregularly-shaped cavities, which, together with the bronchial tubes, contained a brown-coloured fluid, similar to that in the bronchial tubes of the other lung. The larynx and trachea were enlarged, and the mucous membrane of the trachea and larger tubes were studded with small yellowish-coloured specks of lymph. No tubercle was found in any part of either lung. The third rib on the right side was carious, and near it there existed an abscess under the integument. The heart was flaccid and apparently atrophied. It weighed

from ten to ten ounces and a-half avoirdupois. The pulmonary artery and aorta were much dilated. The kidneys were natural, except that the cortical portions were somewhat narrow. One supra-renal body consisted of scarcely anything but loose cellular tissue; the other was converted into a cyst containing a dirty brown-coloured grumous fluid.

Dr. Peacock stated that the body of the miner from which this specimen was removed was the only one which he had had the opportunity of examining after death; but he thought it probable that the lung afforded a characteristic example of the form of disease which proved so fatal to miners, and which is commonly called in the mining districts "miners' asthma," or "miners' consumption." When not otherwise predisposed to consumption, the miners become subject to chronic bronchitis and emphysema when they have scarcely attained middle age, and shortly after that period many of them die with signs of consolidation and breaking down of portions of the lung tissue. When, however, they are predisposed to consumption, they die at a much earlier period, and apparently of true tubercular phthisis. The chief predisposing cause of the pulmonary affections was probably the impure air which the miners breathe when under ground; the disease being called into active operation from the occurrence of inflammation, caused by cold taken in the shafts or at the surface, after the men have been working in warm and ill-ventilated places. It has been thought that the miners are injured by the inhalation of gritty particles, like the French millstone makers or builders, but such does not seem to be the case with the Cornish miners; though the dust of the mines may in some degree be influential in causing disease among the lead miners of the North of England. Portions of the lung exhibited to the Society had been carefully analysed by Dr. Bernays, but no siliceous particles were detected in them. The dark material was found to be carbon. Dr. Peacock thought that the injurious effect of the occupation of mining was considerably aggravated by the very early age at which the men go to work in the mines in Cornwall, many of them beginning before the age of thirteen or fourteen,—that at which this man commenced working underground. The condition of the supra-renal bodies was noticeable in connexion with the peculiarly sallow, dingy complexions of the men who have been long employed in metal mining.

Dr. Peacock, *2nd of May*, 1865.

15. *Specimen of diseased lung from a case of grinder's asthma.*

The specimen has been in my possession for some years. It was taken from the body of a razor-grinder, who had long suffered from grinder's pulmonary disease, but had died from an intercurrent attack of acute pneumonia. The portion of lung shown is from the upper lobe, near the apex; it is consolidated, but some parts are harder than others, and it is intersected by a firm white band, apparently produced by the thickening of inter-lobular tissue. It is now of a dark bluish-grey colour, but is paler than when fresh. On examination of a thin slice under the microscope, a few small, apparently crystalline bodies, irregular in size and shape, were seen embedded in the tissue, which also contained numerous small, well-defined, black masses of various sizes, which gave the lung its peculiar dark colour. On the supposition that these latter might be at least partly due to the presence of oxydized iron, a very thin slice of the lung was taken and immersed for some time in hydrochloric acid; but on examination under the microscope it was found still to present appearances identical with those already described. In order to determine the nature of the apparently crystalline bodies, a small portion of the lung was carefully incinerated in a porcelain crucible; it left a bright red ash, which partially dissolved in boiling hydrochloric acid, leaving a small residue, that gravitated to the bottom of the vessel. On examination of this residue under the microscope, it was found to consist partly of an amorphous deposit, partly of small angular masses, which reflected light powerfully, and polarized light transmitted through them. A portion of this residue being, at the suggestion of my friend Mr. Heisch, Lecturer on Chemistry at the Middlesex Hospital, exposed in a shallow platinum vessel to the fumes of hydrofluoric acid, was entirely dissipated, proving it to be silica. A comparative experiment was tried with a portion of ordinary lung (from a patient who had died in the Middlesex Hospital) which, when incinerated, left an ash not quite so red as that from the grinder's lung, and altogether soluble in boiling hydrochloric acid. The solution of the ash from both lungs gave faint indications of the existence of iron, about equal in both cases; but the absence of free particles of iron in the grinder's lung was determined by bringing every part of the specimen into proximity with a delicate magnetic needle without causing any sensible disturbance.

The disease from which the patient had suffered appears to have been chronic, or as Rokitansky terms it, interstitial pneumonia, and

its cause was doubtless the inhalation of finely pulverized grit given off from the revolving grindstone while the man was at work, and which, as we have seen, was found in the lung after death, in the form of small angular particles of silica. Dr. Greenhow, 16*th of May*, 1865.

---

16. *Specimen of coal-miner's black lung.*

This specimen, like the former, has been in my possession for some time. It was obtained from the body of a collier who had worked in the shallow and ill-ventilated coal-mines near Wolverhampton, and was taken from the free margin of the upper lobe. The general colour of the mass is dark blue, almost black, but it was quite black when fresh, at which time a black juice could readily be expressed from its substance. The pleura is thickened, and the lung is traversed by some firm white bands, apparently formed by the thickening of inter-lobular tissue. The lung cuts toughly, and is very firm and solid, but not uniformly so, some ill-defined harder portions being felt in its substance when handled. Under the microscope, the lung was seen to be studded with small black deposits, apparently irregular both in shape and size, but the examination was not made until it had been for some time immersed in spirit. On boiling a small slice in strong hydrochloric acid, the black deposit was not affected. A portion of the lung, when incinerated, left a red ash closely resembling the ash left from burnt coal. When boiled in hydrochloric acid this ash was partially dissolved, leaving a white or greyish amorphous residue, which did not polarize light but evidently consisted of silica, for it was dissipated on being exposed to the fumes of hydrofluoric acid.

This case appears to have assimilated in its pathological characters that of the razor-grinder. The lung was similarly consolidated and traversed by white bands. Whatever doubts may sometimes be entertained regarding the origin of the black deposit in the lungs of colliers, it appears quite certain that in this instance it arose mainly from the inhalation of finely pulverized coal, for on no other supposition can we explain the presence of the very large amount of amorphous silica obtained from the incinerated lung.

Remarks.—The result of the examination of these specimens of lung accords with the history of the symptoms from which the several classes of operatives exposed to inhale grit or other heavy dust are

practically found to suffer. The earlier symptoms are those of bronchial irritation, namely, slight dyspnœa, cough, and scanty expectoration coloured with the material inhaled. This ailment often proceeds so slowly and insidiously that the sufferer is scarcely aware of its existence until it becomes aggravated by some attack of catarrh, and more or less disables him from working. Hence, overlooking the previous indisposition, he, for the most part, dates the commencement of his illness from the occurrence of a cold. In a great many instances, and especially those in which the dust inhaled is of a light description, the disease often remains bronchial throughout, and presents only the ordinary characters of chronic bronchitis, with or without emphysema. But in other cases, and especially in those in which a heavy dust, such as that given off in the processes of razor-grinding or china-scouring, has been inhaled, chronic pneumonia supervenes after a time, and frequently proves fatal, either in consequence of an intercurrent attack of acute pneumonia, or, after a long chronic course, with symptoms resembling those of very chronic phthisis. Dyspnœa is always a very marked feature of such cases, and is sometimes so extreme as to prevent active locomotion, even while the patient is still able to continue his occupation. The physical signs are also out of all proportion to the amount of disturbance of the general health, which, in constitutionally sound subjects, is much less than in those who are the subjects of pulmonary disease, arising from constitutional cachexia. Sometimes, even when the complaint appears to be far advanced, the discontinuance of exposure to the determining cause, viz., the inhalation of dust, is followed by a most marked improvement of health.

Dr. Greenhow, *16th of May*, 1865.

---

17. *Diphtheritic membrane from the trachea.*

The patient was a child, æt. 3, who was brought to the St. Pancras Dispensary, on Thursday, 19th of April, suffering from some difficulty of breathing, stridulous cough, and febrile symptoms. A mixture was ordered containing some small doses of Vinum antimonii tartarati. Dr. Semple did not again see the child alive, but it was stated that the symptoms improved considerably, and, indeed, the patient began to play and run about until the evening of Sunday, 22nd of April, when the difficulty of breathing increased, with cough and symptoms of suffocation, and before medical aid could be procured the child died.

A *post-mortem* examination was made on the following day, but only the larynx and trachea could be examined. A tubular membrane was found occupying the trachea, and easily detached from that organ; the membrane was also found lining the inner surface of the larynx.

Dr. Semple remarked, in reference to this case, and to others which he had on previous occasions presented to the Society, that the conviction was gaining strength in his mind that diphtheria of the trachea was essentially the same as croup, the latter disease being, in fact, a variety of the former, as was long ago supposed by foreign writers. Trousseau, Bouchut, Guersant, and others, all regard croup as a variety of diphtheria, and call it tracheal diphtheria.

Dr. Semple, 16*th of May*, 1865.

III.—DISEASES, ETC., OF THE ORGANS OF CIRCULATION.

1. *Case of opening in septum ventriculorum. Pulmonary artery and aorta given off from the heart as one trunk.*

The subject of this malformation was the same as that of the encephalocele of the occipital region described at page 12.

The condition of the heart was remarkable. It was of natural size, but instead of presenting two large ascending trunks—aorta and pulmonary artery—there was only one, which after passing upwards for a short distance gave off the right and left pulmonary arteries, and then continued as the aorta, curving, as usual, towards the left side, and furnishing the innominate, left carotid, and left subclavian to the head and arms (*see* Fig. 12). On opening the right ventricle, the single large ascending vessel was found to correspond to the pulmonary artery in its mode of origin, being strictly continuous with the infundibulum of that ventricle, and possessing the usual three semilunar valves.

From the left ventricle no vessel arose, nor was there any depression indicating the position of the aorta; but at the upper part of the septum ventriculorum, and immediately below the semilunar valves of the pulmono-aortic trunk, was an opening of considerable size and of semilunar form, through which the blood must have readily passed during the systole of the left ventricle. The single set of semilunar valves, together with the mitral and tricuspid valves, were perfectly competent.

The arrest of development must here, it is obvious, have taken place

at a very early period, before that infolding of the walls of the bulbus aorticus occurs which divides it into an aortic and pulmonary portion;

Woodcut 12.

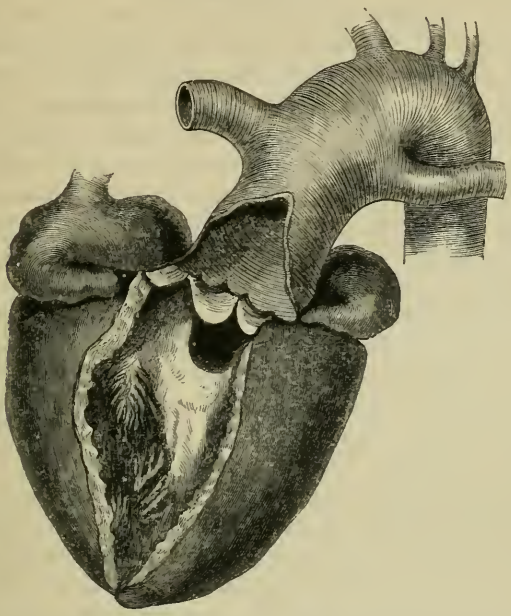


Fig. 12 represents the aorta and pulmonary arteries originating as a common trunk from the right ventricle, and the large orifice in the septum ventriculorum.

but there seems to be no reason for believing that, had there been no malformation of the nervous system, the child might not have lived, though doubtless he would have been the subject of cyanosis.

Mr. Christopher Heath *for* Mr. Henry Power,
6th of December, 1864.

---

2. *Dissecting aneurism of the abdominal aorta.*

T. C., æt. 28, admitted into Middlesex Hospital, under the care of Dr. Thompson, on the 9th of August, 1864, and transferred to Dr. Greenhow's care the beginning of September.

The patient's health had been failing for about a year, and he had been suffering for about two months from sharp pain in the loins, which

came on suddenly, and was at first intermittent, but after a few days became continuous. A week before his admission into the Hospital, a great feeling of soreness supervened in the left side, extending from the axilla to the ileum, followed in a few days by swelling, which increased rapidly. On admission he was much emaciated and extremely pale. Pulse 108, very small and weak. A murmur was faintly heard at the apex of the heart. The external jugular veins were enlarged and distended, and there was a large fluctuating tumour, with pulsation and superficial œdema, at left side of thorax posteriorly, over which a faint systolic murmur was heard. There was dulness on percussion, extending from the left scapula to the ileum and from the spine round the left side to about two inches forwards over the anterior surface of the abdomen.

On the 12th of August there was found to be a loss of sensation over that portion of the surface of the abdomen corresponding to the distribution of the ninth, tenth, and eleventh intercostal, and one or two lumbar, nerves. A few days later another swelling appeared on the right side of the spine, for about six inches upwards from the twelfth rib. This second swelling was accompanied by pain, closely resembling, according to the patient's account, that which preceded the formation of the first tumour; and, as in the first, pulsation and fluctuation could be distinctly felt. After a few days it became quite evident that there was communication between the two tumours, both of which continued to enlarge. The tumours being a little red and œdematous at the surface, some doubts were entertained as to their nature, and at a consultation of the Hospital staff it was determined to solve the question by introducing a very small trocar into the tumour, which was accordingly done, on the 26th of August, by Mr. Moore, at a spot corresponding to the middle of the eleventh rib. Nothing issued through the canula but an ounce or two of thin arterial blood, which flowed in a jerking stream, and under the microscope showed a deficiency of colourless corpuscles. The wound was closed with collodion and lint, healed readily, and no injurious consequences followed the operation. The tumours continued to increase in size; superficial sloughing took place somewhat extensively over their surface, and the patient grew feebler and more anæmic from day to day, until he died of asthenia on the 19th of September.

Post-mortem examination.—On laying open the abdomen, the stomach, liver, and kidneys were all exposed to view. The liver, which had been pressed forwards and downwards by the aneurismal tumour

behind it, extended from two inches and a-half to three inches below the margin of the ribs, weighed two pounds thirteen ounces, and appeared to be healthy. The kidneys were in like manner protruded forwards. On removing the intestines, the posterior part of the abdomen, from the diaphragm downwards as low as the ileum, was occupied by a large aneurismal tumour, deeply grooved along its middle by the aorta which was in front of it. The sac was distended by thin claret-coloured blood, and lined on its anterior and lateral internal surfaces with dense layers of fibrin, which formed a smooth surface towards the inner aspect of the aneurism. The layers of fibrin were less dense, and the walls of the aneurism much thinner, towards the posterior part. The diaphragm was pressed upwards by the aneurism on the right side, so as to form a globular protrusion the size of an orange, that encroached on the thorax as high as the middle of the seventh rib. On the left side, the diaphragm was more evenly pressed upwards as high as the middle of the eighth rib. On tracing the aorta downwards it appeared to be of normal size until it had passed through the diaphragm, immediately below which it opened abruptly into the aneurism; the posterior part of the artery for nearly two-thirds of its whole circumference presenting a free, even, smooth margin, as if it had been cut with a knife. Anteriorly the wall of the artery was spread out to the breadth of one inch and three-quarters, and contributed towards forming the upper and anterior wall of the aneurismal sac. The inner coat of the artery could be traced over the sharp abrupt edge of the vessel, extending upwards for about three inches as a lining to the aneurismal sac, and laterally for about one inch and a-half towards the right and four inches and a-half towards the left. The aorta was atheromatous in patches, the atheroma being of yellow colour and ligamentous appearance. One thick plate of this deposit existed in the posterior wall of the artery, at, and for a short distance above, the part where the vessel ended abruptly at its entrance into the sac. The communication of the aorta with the sac at its opening of exit was also abrupt, but less so than at its opening of entrance, and the vessel appeared to be of normal calibre, both above and below the aneurism. The breach in the posterior wall of the artery, through which it communicated with the cavity of the aneurism, was one inch and a-quarter in length, and extended from the diaphragm to a point a little above that at which the renal arteries were given off. The cœliac axis and the superior mesenteric artery opened directly into that portion of the arterial wall which contributed to form the anterior

wall of the aneurismal sac, so that a probe introduced into the orifices, made by cutting them across, passed directly into the cavity of the aneurism. The kidneys were pale and flabby, and were firmly embedded in dense cellular tissue, which was continuous with the cellular coat of the artery and united with the arterial wall in forming the anterior wall of the aneurism. The spleen was healthy, but had been pushed upwards. The vertebral column was for several inches entirely included in the aneurism, which had eroded a considerable part of the bodies of the four lower dorsal and two upper lumbar vertebræ, the intervertebral cartilages remaining apparently healthy and uninjured, and projecting considerably beyond the bones. The three lower ribs on the left side and the last rib on the right were dislocated, partially eroded, and divested of periosteum. The eleventh rib on the right side was also partially denuded of periosteum, but still attached to the vertebræ. The psoas muscles on either side were disorganized and infiltrated with greyish-red pulpy matter and pus. On opening the thorax, the lungs were found to be adherent to the ribs and diaphragm; the lower parts of the lungs were carnified, and the remaining parts œdematous, but otherwise healthy. The pericardium was healthy; the heart was flaccid and pale-coloured, but otherwise normal. The aorta, just above the semilunar valves, had several yellow, ligamentous-looking, atheromatous patches, but was not dilated.

Remarks.—From a careful examination of the parts after death, I came to the conclusion that there had been first a small sacculated aneurism, corresponding in size to the portion of inner arterial coat reflected over the sharp edge of the artery. It seems probable that the failing health which for so many months preceded the appearance of the more urgent symptoms was due to the existence of this aneurism, and that the accession of the later symptoms was coincident with the giving way of the sac and the formation of the false aneurism. The impunity with which the aneurism was punctured is a fact of great practical importance, inasmuch as it shows that with discrimination and due care in the operation this means may be safely employed in similar cases in order to determine the nature of doubtful tumours. Another point of much interest in the history of the case is the fact, that although superficial sloughing of the integument, with a very copious oozing of bloody serum, took place nearly a fortnight before death, yet the aneurism itself, in spite of its unusual size and of the evident thinning of its posterior wall, did not give way, but the

patient died of extreme asthenia. The mode of death I am disposed to attribute to the large abstraction of fibrin from the blood, which must have taken place in order to furnish the enormous masses of that material collected in the aneurismal sac.

Dr. GREENHOW, *6th of December*, 1864.

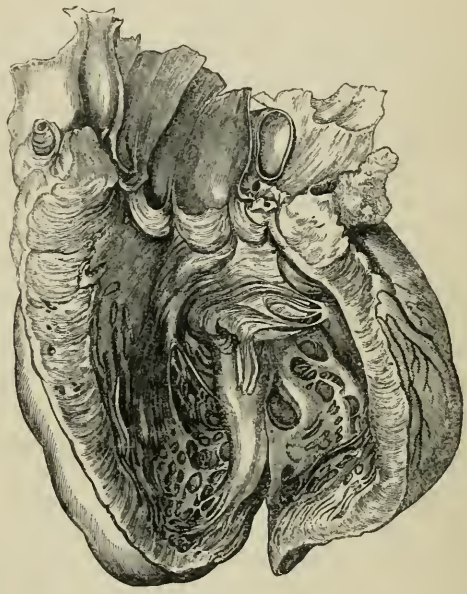
---

3. *Fleshy column of diseased mitral valve ruptured during violent vomiting.*

Dr. Peacock exhibited the heart of a female, æt. 21, who had died recently at the Victoria Park Hospital. She had been an in-patient of the Hospital in 1851, labouring under cardiac symptoms, the sequence of an attack of rheumatic fever two years before. She had not been under medical care for some time, and was in her usual health, when she was taken in a cab from her home in Artillery Street, Bishopsgate Street, to the Victoria Park Hospital, to be examined for admission. The motion of the cab was very uneasy and she felt it much. On reaching the Hospital she was put down at the garden gate, and on walking to the out patients' waiting-room, was seized with violent vomiting, had difficulty of breathing and faintness, and when she reached the waiting-room was pulseless at the wrist and apparently dying. When seen by Dr. Peacock, a few minutes after her arrival, she had in some degree rallied; the pulse was feebly to be felt at the wrist, but she was too weak to be carefully examined, and the loud tracheal rhonchus rendered it difficult to hear the cardiac sounds. It was, however, thought that there was a feeble systolic murmur at the apex of the heart. She was removed to bed, but died in a few hours. On examination after death, the pericardium was found to be entirely attached by old and firm cellular adhesions. The heart, when deprived of the adherent pericardium and freed from coagula, weighed twenty ounces and a-quarter avoirdupois (the healthy range for females being eight to ten ounces). There was considerable dilatation of the left ventricle, but the walls were not increased in thickness, measuring from .1776 to .3996 of an English inch (the healthy average in females being .497 of an English inch). The aortic aperture was somewhat contracted, measuring 2.93 of an English inch (average in females 3.019), and the ventricular surfaces of the valves were considerably thickened, while the crescentic edges were free. The left auriculo-ventricular aperture was slightly diminished in capacity, admitting only a ball measuring

3.996 of an English inch in circumference (the healthy average in females being 3.996 of an English inch.) The mitral valve was considerably thickened and indurated, and the chordæ tendineæ of the free fold of the posterior columna carnea were entirely torn from their attachments, so that the valve was entirely loose, and must have admitted of free regurgitation (*see* Fig. 13). The walls of the right ventricle were some-

Woodcut 13.



what thickened, measuring .1776 of an English inch (healthy average .177 of an English inch). The right auriculo-ventricular aperture was slightly constricted, measuring 3.996 of an English inch (healthy average 4.562 of an English inch), and the tricuspid valves were thickened and firmer than natural. The lungs were much congested, and the bronchi contained bloody mucus. She had had several previous attacks of sickness, but no disease of the stomach was detected after death.

Dr. Peacock remarked there could be little doubt that the tendinous cords had been torn from their attachments during the violent vomit-

ing soon after the girl left the cab, for her mother expressly stated that she did not suffer at all seriously when she left home and that she had not the slightest idea that there was any risk in taking her to the Hospital. Though cases of rupture of the valves or their attachments, when diseased, were of more common occurrence than such injuries to healthy valves, yet all such cases were very rare. The case did not throw light upon the effect of universal adhesion of the pericardium to the heart on the functions and nutrition of that organ, for there was considerable disease both of the aortic and mitral valves, which was sufficient to explain the great increase of weight. He had, however, seen specimens in which the pericardium had been universally attached, and evidently as the result of inflammation of old date, in which the size and weight of the heart did not exceed the healthy average. Dr. Peacock, *20th of December*, 1864.

---

4. *Dilatation of right side of heart, associated with extremely dense deposit of tubercle in lungs.*

A young soldier, æt. 18, of very delicate appearance and slight physique, was admitted into the Hospital, Scots Fusileer Guards, on the 1st of November, 1864. He complained of throat affection, and the fauces were slightly inflamed. No pyrexia, cough, expectoration, dyspnœa, or other symptom of chest disease was complained of. The throat got well in a few days, but the lad remained in a very cachectic state, the tongue furred, appetite bad, and spirits depressed.

It was considered that cachexia, antecedent to phthisis, was present. The respiration was generally tubular throughout both lungs. His tongue cleaned a little, his appetite improved under treatment, and it was arranged that he should leave the Hospital for the country on the 6th of December. He had never been confined to bed, and he took exercise in the Hospital yard each day. On the morning he was to have quitted the Hospital he was found by the hospital serjeant at an early hour in a state of collapse. When seen by the medical officer at 10 A.M. his pulse was extremely rapid and weak, surface of body cold, face livid, lips blue, respiration very hurried. The chest was tolerably clear on percussion everywhere, there being no defined dulness in the cardiac region. There were moist râles in the lungs, together with loud bronchial respiration, which anteriorly almost masked a slight cooing murmur with the first sound audible below the nipple. He

did not rally. Evidences of congestion of the lungs supervened, and he died on the morning of the 7th of December, at 1, P.M.

Post-mortem examination, twenty-four hours after death. — Chest. — Lungs both in a state of congestion and solidified throughout by miliary tubercle to an extent completely displacing the lung tissue.

Heart.—No fluid in the pericardium; viscus enlarged, fatty and pale; weight ten ounces and a-half.

The *right auricle* extremely thin, greatly dilated, blackened in colour externally, so as to be almost melanotic in appearance.

Right ventricle.—The wall very thin also, the tricuspid valve imperfectly fulfilling its function.

Left ventricle slightly hypertrophied.

The *mitral valve.*—Several warty vegetations, apparently of recent formation, were found at the base of it, one as large as a swan-shot.

Remarks.—There are several points of interest in this case in a practical point of view:—1st. The absence of any prominent symptoms during the period of several weeks and until the day before decease. The loud bronchial respiration, masking the heart's feeble sounds, was considered indicative of tubercle (viewed with the generally cachectic state of the lad), and to mark the approach of phthisis in a more advanced stage. Except a somewhat feeble circulation, none of the several signs of cardiac disease were present then. The murmur was only audible after the accession of the fatal seizure, and even subsequently, the night before decease, it could not be heard.

2nd. The lesion of the right side of the heart with reference to its effect in causing deposition of tubercle in a subject predisposed to such disease.

I have never met with a case in which there was so general and dense a deposit of tubercle. Scarcely a particle of either lung was free from it, and as the livid appearance and extreme dyspnœa indicated, the poor lad's state was positively that of asphyxia. I am therefore inclined to consider that the deficient propulsive power of the right side of the heart, and consequent imperfect function of the lungs, exercised an important influence in generating disease in the latter organs.

The proximate cause of death may have been congestion of the little

portion of lung tissue capable of fulfilling its function, arising from a chill whilst taking exercise the day before decease.

Dr. Frederick Robinson, 20*th of December*, 1864.

---

5. *A case of plugging of the right and left branches of the pulmonary artery in rheumatic fever; rapid death.*

Mrs. K., æt. 49, of temperate habits, had been under my care for about a fortnight, suffering from a severe rheumatic fever. The muscles appeared to be more affected than the joints; she suffered most in her back and lower limbs. For a few days her left knee and ankle-joint were very painful, but there was no swelling or redness of them. The heart was not discovered to be implicated in this attack.

The urine was red and scanty, not albuminous. This patient had had a very severe attack of the same kind many years ago; her heart was then said to be affected. She was long in recovering, and believed herself that her heart had been diseased from that time. She had long been in delicate health, and often lost blood from piles.

In her present illness she was more anxious and irritable than patients usually are in this disease.

The treatment consisted of a free use of alkalies combined with lemon juice (she was often sick), purgatives, opiates, and stupes. Her diet was chiefly milk, beef-tea, and diluents freely.

After seven or eight days of acute suffering and fever, she improved very much; the pains and fever nearly left her; but she remained very weak, anxious, and restless. On the morning of her fatal seizure she took a comfortable breakfast—her friends thought her decidedly better than she had been,—when suddenly she started up in her bed and said she was choking and must die. She vomited a little, and seemed to have a slight fit. In about fifteen minutes I was by her bedside. She was held up in bed in a sitting posture, and presented a most distressed state; she laboured at breathing, and was then breathing forty-eight times in a minute, deeply too; at the same time she was constantly complaining that she could not breathe. She had scarcely a thread of pulse; soon it could not be felt at all in either wrist, neither in her lower extremities; in her carotids there was a feeble pulsation. The heart was beating tumultuously and irregularly, but without other morbid sounds. She was sensible to the last. She complained

of severe pain in her right side, also afterwards in her left, then of pain in her abdomen, and towards the last, of distressing pain in her back. Her nose, cheeks, and ears were cold and pinched; her hands and feet were of a dirty-white colour, cold and shrunken; she had occasional cramps in her legs; her forehead was hot, her breath markedly cold; her chest showed no dulness on percussion in any part; the respiratory sounds were loud back and front, and were heard in all parts of the lungs. I laid my patient back on the bed, administered ammonia, brandy and coffee, and æther, which she swallowed with some difficulty and impatiently, but no effect in restoring the circulation was produced; her pulse could scarcely now be felt; she was very restless and vomited occasionally; she wanted constantly to be raised up or shifted, and often said she could not breathe.

This state continued with little variation for about an hour, when she insisted on being turned on her left side; her breathing then dropped to thirty-six in the minute; in a few minutes she quietly died; there was not any cough or mucous rattle in this attack, and for most of the time there was no pulse to be felt in the wrists.

I had never met with such a case before; still the symptoms appeared so decidedly to point to plugging at the right side of the heart—in other words, to nearly a total stoppage of the stream of blood before the lungs—that I had no difficulty in coming very soon to a conclusion that such was the case, and stated this opinion to the friends, and further said that my patient would probably very soon die.

The absence of pulse, the shrunken, white, pinched surface of the body, showed that the circulation was cut off somewhere. The hard, sufficient breathing, whilst to the feelings of the patient there was an urgent want of breath, and the cold breath, showed that blood did not reach the air cells so as to satisfy the respiratory function; there was no oxygenation of the blood effected, no heat generated, so that, in short, the stream of blood must have been stopped either in the right side of the heart or in the pulmonary artery, right and left branch.

It is, I think, worthy of note, that this patient survived full an hour from the time of the sudden seizure described above.

On examining the body after death, I found no external sign of disease of the veins of the extremities, and no swelling of any joint. I opened the chest only. The heart was flabby and pretty nearly empty of blood; there were fragments of clot in the right cavities; mitral valves thickened, probably from old mischief. On laying open the pulmonary artery I found a firm, fibrous plug nearly filling both the right and the

left branch, extending into the vessels about three inches in each, and firmly lodged. These masses tapered a little at the distal end; the left mass seemed to be of older formation than the right; there was no plug in the common trunk of the pulmonary artery. The specimen exhibited to the Society showed pretty well the state of things as described. The dissection, however, for want of time, was not so carefully done as it might have been. Both the history of the case and the condition of the pathological specimen show, I think, pretty plainly that the fibrinous deposit had been going on before the sudden seizure.

Dr. Wm. Martyn, *20th of December*, 1864.

---

6. *Case of rupture of one of the musculi papillares of the tricuspid valves.*

The heart was taken from a woman, æt. 23, who was admitted, about seven weeks after a second confinement, in an exhausted condition, caused by starvation and pelvic inflammation together.

She lived only five days. When admitted into hospital she was in a state of collapse, but from this she partly rallied. There were all the signs of intense peritonitis; and a very loud rough systolic murmur was heard at the base of the heart. As the patient had evidently but a short time to live, I did not make a very careful examination of the heart, but I remember distinctly being struck with the rough and intense character of the cardiac bruit. At the *post-mortem* examination, I found the whole cavity of the pelvis in a state of inflammation, the uterus surrounded with pus, the ovaries full of it. The omentum and intestines matted together almost universally, in some places a large quantity of thick pus escaping when they were separated. There was pneumonia of the greater part of the right lung: no trace of tubercle. Liver was almost honeycombed in appearance, very pale in colour, and crepitant on pressure with the fingers. The notes I made at the time about the heart are—

"Pericardium contains half an ounce of clear yellow serum; surface of pericardium smooth. Soft fibrinous clot in pulmonary artery and aorta, and in both right and left cavities. On the tricuspid valve, at its free margin, are numerous large, firm, nodulated vegetations, and recent soft ones are also attached to the columnæ carneæ. One of the musculi papillares, near the origin of the chordæ tendineæ, ruptured, the broken extremity being covered over and rounded with fibrinous deposit. Endocardium of a bright red colour. Mitral valve healthy; aortic and

pulmonary also. Endocardium of the left ventricle, and extending for two inches along the aorta, of a bright red colour, smooth. Tissue soft and flabby, with fatty degeneration."

There is no account of when or how the rupture occurred, but most probably it took place some time before admission into the Infirmary. The accident seems to be extremely rare. Among eleven cases of rupture of the valves, Dr. Peacock found but one case affecting the tricuspid, and I cannot find an account of any other.

Mr. William Squire *for* Mr. W. D. Spanton,
17*th of January*, 1865.

---

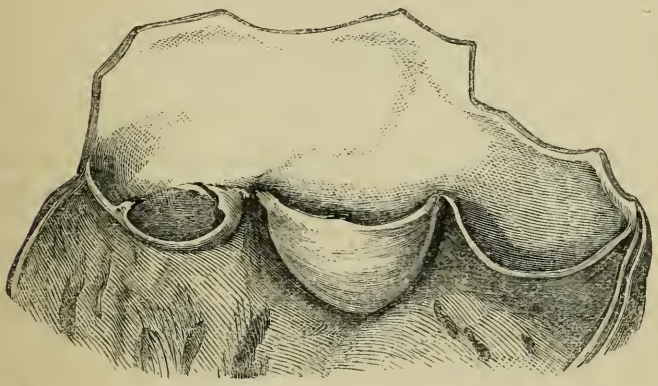
7. *Entire loss of two of the pulmonary valves.*

Joseph S., æt. 31, came under Dr. Wilks' care, at Guy's Hospital, suffering from phthisis. He was at the same time affected by a heart disease, the nature of which was not very clear. A double bruit was heard over the valves of the heart; that is, a systolic and diastolic *souffle* of a loud and distinct character; it became less marked towards the right and in the course of the aorta, but was equally intense, or even somewhat more distinct, in a line traced upwards towards the left clavicle. The pulse gave no indication of aortic regurgitation. The question of disease of the pulmonary artery was considered, but dismissed on account of its extreme rarity; for although on several occasions we have been able to diagnose an obstructive disease of the pulmonary orifice where a single bruit had existed, yet the diagnosis failed in this case, where a diastolic bruit was also present, as it suggested, what was considered very unlikely, a regurgitant condition of the pulmonary artery. It was thought therefore most likely to be an aneurism, or some peculiar condition of the aorta, which had given rise to the sounds.

The history of the man was this:—He had as a youth worked at the Arsenal at Woolwich; but nine years ago he had an attack of rheumatism, after which he was obliged to give up laborious employment, and he turned cabman, following also the usual habits of his class by becoming very intemperate. He suffered during the last few years from occasional difficulty of breathing, but never sufficiently to oblige him to desist from work until about four months before his death, when pulmonary symptoms appeared. He was admitted with extensive disorganization of both lungs, of which he died.

On *post-mortem* examination, the disease which had caused the bruit was found to be situated in the pulmonary artery, two of the valves of which had almost entirely disappeared. One was perfect; another was quite absent, there being merely a ridge or raised border marking the site of its former existence; in the place of the third, there was a small ragged piece of membrane remaining as a vestige of the valve, and hanging loose on each side (Fig. 14). There was no thickening of

Woodcut 14.



the perfect valve, nor was there any trace of any former inflammatory action having existed at this spot. On the left side two of the aortic valves were adherent for a small portion of their surface, thus indicating the existence of a former and remote endocarditis. The heart was of the usual size and form; the right ventricle not at all enlarged.

The *post-mortem* thus clearly revealed the causes of the sounds, which, if they had been regarded simply in the light of their physical cause, without any opinion as to the improbability of such disease, would have suggested at once the true diagnosis of regurgitant disease of the pulmonary artery. As regards the pathology of the lesion, the question remains whether the destruction of the valves took place at the time of the rheumatic attack ten years before, or whether it was congenital? The history of the illness dating from the latter period suggested the first opinion; whilst, on the other hand, the absence of all signs of inflammation, with the simple loss of substance, suggested the latter supposition. This is strengthened also by the fact that disease of the pulmonary orifice is more likely to occur at fœtal life than at an

extra-uterine period, although this theory is merely carrying back the time of the ulcerative endocarditis to a more remote period.

Dr. Samuel Wilks, 17*th of January*, 1865.

---

8. *Case of aneurism of the aorta pressing upon the pulmonary artery.*

Edward N., æt. 38, of temperate habits was admitted under Dr. Johnson, the 18th of April, 1864. Has never had rheumatic fever, scarlet fever, or renal disease. Long-winded when young. Has had winter cough four years, which has been much worse during last winter, and especially lately. Has never spat blood. Has been troubled with palpitations occasionally during the last three months, and has had pain in the left shoulder.

On admission, chest very large, fairly expansive. Cardiac dulness extends lower down than usual; chest resonant elsewhere; respiration rather loud.

The apex of the heart beats two inches below the left nipple, and there is pulsation in the scrobiculus.

Loud systolic (mitral?) bruit, best heard two inches below, and one inch internal to the left nipple. Second sound very weak; pulse wiry. The bruit faintly audible behind. No albumen in the urine. Bowels open. He is rather hoarse, and has been so for three months. Complains of some difficulty in swallowing, the food seeming to be pushed to the right side of the œsophagus. He gradually improved, and was discharged "relieved" on the 1st of May.

Readmitted on the 25th of September, 1864. Has been abroad lately. Has not been well since he left the Hospital; suffering from indigestion and palpitation. Dropsy came on a week before admission; it began in the feet and has steadily increased. The breathing has become difficult. His work has been light, and he has lived temperately. He has had no cough.

He now suffers much from dyspnœa. Chest everywhere resonant on percussion, but not abnormally so. Expiration loud and rather prolonged.

The loud systolic bruit, supposed to be mitral, is still heard at the apex. Pulse 100, small and weak. Since this attack came on his urine has been very scanty and high-coloured, and contains about one-eighth of albumen. Complained of pain in the scrobiculis cordis, which was relieved by dry cupping. He became somewhat better for some

time; but on the 5th of October his face was more swollen and blue; cough worse; breath shorter; pulse 104; respirations 24, laboured. No abnormal sounds on auscultation over the lungs. Expectoration very slight; jugular veins distended; lips blue. He gradually became worse, without any special change in the symptoms, and died on the 14th of October, 1864, at 10.30 P.M.

Post-mortem examination.—Heart.—The mitral valve was healthy. The aorta, besides being much diseased and dilated, was pouched in two or three places into a kind of aneurism, and one of these pouches pressed upon and much narrowed the orifice of the pulmonary artery. The right ventricle formed the apex of the heart, and the systolic bruit, supposed to be mitral, was probably tricuspid, or possibly due to the obstruction at the pulmonary artery.

The lungs were not at all engorged, for very little blood could enter them.

The liver, kidneys, and spleen were much congested.

Dr. JULIUS POLLOCK, *7th of February*, 1865.

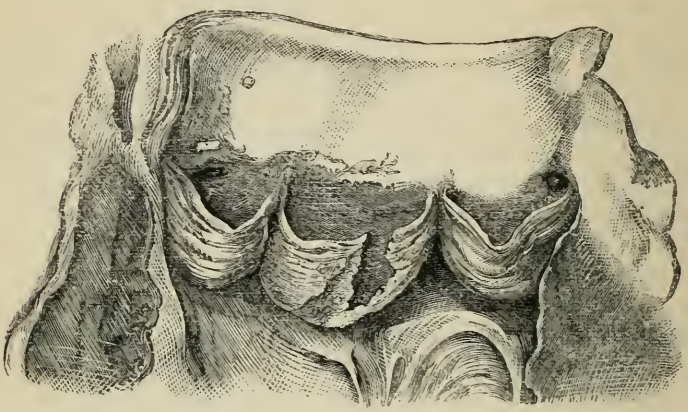
---

9. *Rupture of one of the aortic valves.*

A young man, æt. 19, was admitted into Guy's Hospital, on the 4th of December, and died on the 6th of December, 1864. He fell from a height, alighted upon a stone, and violently struck his left side, the consequence of which was that he lacerated a portion of the intestine, and died on the third day after the accident from peritonitis. On his admission, it was observed that he had considerable oppression at the chest, and had much distress in breathing; but unfortunately the stethoscope was never placed on his chest. The *post-mortem* examination showed that besides the injury to the abdomen a laceration had taken place in one of the valves of the heart. There was no mark of bruising on the chest, or of any sign of injury within, but on opening the heart, the most posterior valve was found torn transversely through, from its edge to the base, not through its median line, but dragged away from its attachment on one side (Fig. 15). Thus only a small ragged portion remained attached to the aorta, whilst the bulk of the valve was free to flap backwards or forwards. A small deposit of fibrin had already commenced to take place on the ragged edges. There could thus be little doubt that the distress which the lad suffered was due to the injured valve.

With regard to the cause of the laceration, it can only be explained on the supposition of a sudden, unexpected, or irregular contraction of

Woodcut 15.



the aorta taking place, the valve giving way from the undue and unequal pressure momentarily put upon it.

The interest of the case lay in the fact of the opportunity of witnessing the laceration so soon after its occurrence, which was owing to the patient having received other mortal injuries; for, as a rule, an injury to a valve is not immediately fatal, and therefore, although there may be every reason to believe that the organ was previously in a healthy condition, and even should the *post-mortem* examination reveal a laceration, yet the question always arises as to the proof of the integrity of the valve prior to the lesion. The difficulty arises from the fact that the torn surfaces so soon become altered by inflammatory processes and deposits from the blood, that no difference is apparent between an injury followed by disease and a disease which is followed by a mechanical injury. We know, too, as a daily observation, that patients will have disease of the aortic valves without their knowledge of any cardiac symptom, or that, having had such disease for years, they will trace its origin to a comparatively recent period, to the occasion of some sudden or unusual exertion, the time of illness being reckoned from the aggravation of the symptoms. It is thus very difficult when, on *post-mortem* examination, there is found much disease of a valve, accompanied by a rupture, to decide which was the first

morbid process. Where, however, the health has been previously good and the patient young, and there is a history of a sudden accession of cardiac symptoms after some violent exertion, we may believe that an injury has taken place.*

In most cases, however, the injury is not a mortal one, and thus the interest of the present example lay in the opportunity given for so soon witnessing the character of the lesion.

Dr. Samuel Wilks, 21*st of February*, 1865.

---

10. *Rupture of aorta from injury.*

Thomas F., a strong, muscular man, was lifting a barrel of beer into a cart, when it fell, and, striking the upper part of his chest, killed him instantly. On examination of the body, the upper piece of the sternum was found to be fractured, and there was much blood effused in the mediastinum. The heart and anterior part of the aorta were uninjured. On removing the latter, however, it was found to be torn completely through on its posterior surface, the laceration extending transversely from the under surface of the aorta to the origin of the left carotid artery. The rent passed directly through all the coats and was rather jagged. Near the laceration there was another independent slight laceration of the inner coat alone.

The rupture of the vessel took place, probably, in consequence of the direct pressure put upon it by the fall of the heavy barrel; it burst, in fact, at the moment when it was distended with blood. If it were supposed that the injury was not due to simple pressure, but rather to a sudden and over violent contraction of the aorta, the case might well be contrasted with the one which precedes it, where the aortic valve was lacerated from the last-named cause, and then a question would arise, why in one case a valve should give way, and in another case the aorta itself, when the vessel is submitted to any unwonted stimulus which could cause a more than usually violent contraction?

The present case also illustrates another point of interest, in the fact of deep-seated parts being often the subject of injury when the body has been submitted to superficial violence. The explanation is to be found often in simply mechanical causes, whereby the most fixed parts

* Such cases are related by Dr. Quain in the *Edinburgh Monthly Journal* for December, 1846.

become separated from the most moveable, and thus the weakest structure soonest suffers. The organs during life being in a state of tension, high vascularity, and mutual connection, when the body falls from a height, or is run over, various internal displacements or lacerations may take place according to the circumstances of the accident.

Dr. Samuel Wilks, 21*st of February*, 1865.

---

11. *Malformation of the septum ventriculorum from a patient who died of diphtheria.*

Joseph C., æt. 24, a railway porter, and a very muscular and powerful man, was admitted, under the care of Mr. Quain, into University College Hospital, on the 27th of December, 1864, and it was on the 28th of January following that I was requested by Mr. Quain to see the patient. When he was first admitted he had some syphilitic erythema and psoriasis, and several mucous tubercles; he had also suffered from sore throat before admission. He went on well (the syphilitic symptoms much improved) until about the 22nd of January, when he began to have cough and some dyspnœa, both of which increased rapidly in severity, so that when I first saw him the dyspnœa was intense. No exudation whatever then existed in the fauces or anywhere within sight; but some had been observed on the tonsils at an uncertain date between the supervention of the dyspnœa and my seeing him; he had also coughed up some large pieces of false membrane, which, from their size, appeared to be casts of a portion of the trachea or of a large bronchus. The case being one of diphtheria, the patient was placed under my care; but he got worse, and died on the 31st; his breathing was very laboured during the whole time I saw him. He had constantly a notable amount (about one-fourth) of albumen in urine, but no œdema of ankles.

On making a *post-mortem* examination, the lungs were found to be somewhat emphysematous. The exudation matter in the bronchi was very remarkable, for it appeared difficult to understand how the patient could have survived so long with the bronchi so filled up; they were almost everywhere completely full of exudation matter, which extended even, in many places, to the tubes of almost the smallest size, or of not more than one-twentieth of an inch in diameter.

With regard to the heart, though it was otherwise normal, there

was a great peculiarity of the septum, for just below the aortic valves there was a remarkable depression of the septum to the size and depth of half of a small cherry; this cavity bulged towards the right ventricle, and seemed to originate in a remarkable thinness of the ventricle at that part.

This malformation is a rare one; but it is situated at a point where perforation of the septum is most commonly met with. All muscular fibres appeared to be entirely wanting over the area of the depressed part, and this being consequently rendered unusually weak, was unable to resist the force of the blood pressing against it during the systole of the left ventricle. Dr. Hare, *7th of March*, 1865.

---

12. *Congenital malformation of pulmonary valves.*

Rebecca B., æt. 6, an out-patient at St. Bartholomew's Hospital, under Dr. Edwards. A healthy-looking, well-formed child. Face very slightly dusky; no unusual tint detected elsewhere; no clubbing of finger-ends. Pulse 108, regular, of moderate volume, but slightly thrilling.

Breathing has always been short from birth; the dyspnœa increased by the slightest cold; and she has suffered from frequent attacks of epistaxis to a considerable extent. No rheumatic history. Father and mother are alive and well. Maternal grandfather suffered from morbus cordis.

Impulse felt all over cardiac region, with a purring tremor at the base. The vessels at the root of the neck pulsate forcibly, but equally, on the two sides.

A very loud systolic murmur, of whirring or sawing character, heard all over the chest, but loudest at the base; is very loud under the left clavicle and in the left carotid; may be heard in the corresponding region on the right side, but less distinctly; is very distinct at the inferior angle of the left scapula; fades away towards the apex of the heart.

No change was noticed in the physical signs during the eighteen months she was under observation. Death took place from erysipelas of the left thigh in connection with disease of the hip joint.

Post-mortem examination.—Nothing abnormal in the arrangement of the great vessels of the thorax; but the ductus arteriosus admits the passage of a fine probe.

Heart.—In the foramen ovale a wide direct opening, unequally divided by a fibrous band; tricuspid valve thickened and contracted, the tongue-shape of the cusps being lost. The right ventricle enormously hypertrophied, the thickness of its walls being about equal to the diameter of its cavity. The pulmonary artery, looked at from above, presents a cup-shaped extremity, from the base of which, a little towards its anterior aspect, there rises into the cavity of the vessel a small triangular projection, a minute triangular aperture at the apex of which is the only direct communication between the artery and the ventricle. The mitral valve is apparently healthy; but the aortic valves are somewhat thickened, and two of them have been fused into one.

The calibre of the pulmonary artery is normal; but its coats are certainly thinner than usual.

Dr. Andrew, *7th of March*, 1865.

---

13. *Ruptured chordæ tendineæ of the mitral valve.*

J. H., æt. 42, under Dr. Johnson, admitted 25th of January, 1865; married; three children.

When sixteen years old she had rheumatic fever. Five years ago she again had rheumatic fever. Eleven weeks ago, while running in Fleet Street, she suddenly had to stop, feeling intense pain shooting across her chest, with palpitation and dyspnœa. She got worse, and came into King's College Hospital.

The pain, palpitation, and dyspnœa are very bad, and she is getting weaker. For the last three weeks her legs have been swelling, and they are now very tense and firm on pressure. She sleeps badly, being suddenly roused by fits of dyspnœa. Three weeks ago she began to spit blood, but in very small quantities. She now expectorates blood at each fit of coughing.

Pulse small and thready, about 165. Urine high-coloured, alkaline, and contains a small trace of albumen.

The heart beats in a trembling, irregular manner, and so quickly that it is impossible to say whether there is a bruit or not, but there is no doubt either mitral obstruction or regurgitation. Dr. Johnson diagnosed rupture of one or more of the chordæ tendineæ of the mitral valve.

Her legs were punctured; they subsequently inflamed, and vesicles formed on the skin.

Her lips and nose became blue, and also the fingers of the left hand. She died at 12 P.M. on the 30th of January.

Post-mortem examination, fifteen hours after death. — The lower lobe of the right lung was a mass of pulmonary apoplexy, and there was a patch of the same in the lower lobe of the left lung, almost as big as a walnut.

The pericardium contained four ounces of serum. The heart was large, the left ventricle being hypertrophied more than the right; one of the chordæ tendineæ of the mitral valve was ruptured. Mitral valve diseased, and the orifice contracted.

The aortic valves a good deal thickened.

Liver healthy, but engorged. Kidneys granular, capsules slightly adherent. Stomach healthy.

Dr. JULIUS POLLOCK, *7th of March*, 1865.

---

14. *Aneurism of the basilar artery.—Rupture and effusion of blood into the sheath of the spinal cord.*

History.—G. W., æt. 37, was admitted into St. George's Hospital, under the care of Dr. Fuller, on the 22nd of February, 1865. He was reported to have been a sober and temperate man; but he received a blow on the head whilst he was in the Crimea, and had ever since been subject to fits of excitement on taking even a single glass of beer. Nevertheless he had not been subject to headache, and had ordinarily enjoyed good health.

Five days previous to his admission into St. George's, he had been seized with diarrhœa, which was with difficulty controlled, and on the following day he had five fits of an epileptiform character which lasted with short intermissions, from 1 to 12 P.M., during which time he did not recover consciousness. On the following day his legs were very weak, but he appeared tolerably well, and did not complain of headache or other ailment. He remained in the same condition until the evening before his admission into St. George's, when he had another fit of a convulsive character, which lasted an hour and a half, and left him in a state of unconsciousness, from which he had not recovered at the time of his admission.

When first seen at the Hospital, he lay perfectly still, with his eyes closed, and he was so far insensible that he could not be roused to

speak or put out his tongue; but he gave proof of partial consciousness by an expression of displeasure whenever an attempt was made to rouse him, and also by forcibly withdrawing his limbs if they were moved from the position in which he had placed them. It was thus ascertained that there was not perfect paralysis either of motion or sensation, and it appeared probable that if paralysis existed it was very slight. The skin was cool; the pupils were somewhat contracted, but both equally so; the pulse was 84, soft and regular, and the bowels were reported costive; no urine could be obtained for examination.

During the day he gradually recovered consciousness, and at 10 P.M. he spoke, and afterwards swore loudly at the nurse. About 3.30 A.M. on the 23rd, he was observed to tremble and shake, but he was not convulsed; and he died, without any other symptom, in the course of a few minutes.

Examination thirty-four hours after death.—The convolutions of the brain were flattened and the vessels on the surface were unusually injected. The ventricles contained a small quantity of clear serum, and also a minute dark-coloured clot, resulting from blood, which had evidentally run in along the choroid plexus. The pons Varolii and medulla oblongata were completely embedded in a large dark-coloured coagulum: the fourth ventricle was filled with blood, and the coagulum passed down the cord, inside the dura mater, entirely surrounding the cord as far as the cauda equina, and producing great distension of its sheath. The clot was traced to the rupture of a small aneurism, about the size of a pea, on the basilar artery. The other portions of this artery and the other cerebral arteries were only slightly atheromatous. The left ventricle of the heart was somewhat contracted; the valves were healthy; the aorta was slightly atheromatous. In one of the kidneys there was a considerably sized cyst, but otherwise the structure of the kidneys appeared natural. There was nothing noteworthy about the other organs.

The case is interesting as a well-marked example of a rare form of disease; so rare indeed, that two instances only have been recorded in the *Transactions* of our Society. It is interesting also in a physiological point of view, as proving the occurrence of epileptiform seizures, and partial, temporary paralysis, such as in former days was attributed to so-called serous apoplexy, as the result of slight sanguineous effusion. It scarcely admits of doubt that some oozing of blood took place from the aneurismal sac five days before his death, when convulsions first occurred; that the oozing recurred when the convulsions recommenced

on the evening before his admission into the Hospital, and that he was rapidly recovering from the effects of this second effusion when the final bursting of the sac and profuse outpouring of blood took place, which put an end to his life in the course of a few minutes, on the morning after his admission into St. George's Hospital.

Dr. Henry William Fuller, *7th of March*, 1865.

---

15. *Extensive disease of aorta in a young man.—Sudden death.*

Deceased, æt. 30, a cooper, was engaged in planing wood, when the plane fell from his hands, he threw his arms up, and fell backwards upon the deck, dead.

He had been actively employed in his trade for about two years on board Her Majesty's ship "Virago;" had been very seldom on the sick-list, and never with rheumatism, nor had he ever complained with symptoms referrible to disease of the circulating system.

These facts, and that of deceased having died at so young an age, conveyed to my mind the impression that the pathological condition of the aorta was of sufficient interest for presentation before the Pathological Society.

The entire internal circumference of the vessel, for two inches beyond the valves, was deeply injected (stained?) of a port-wine colour, and corrugated; two deposits of calcareous matter existed just above the line of the valves, and one of these, of triangular form, terminated in a sharp point, easily hurting the finger pressed upon it. The free borders of the valves were hard and thickened, and the musculi pectinati were very large.

The cause of death seems to have been an accelerated circulation from local irritation, causing spasm, reflected back upon the heart.

Mr. John S. Gabriel, R.N., *21st of March*, 1865.

---

16. *Rupture of the left internal carotid artery.*

The patient from whom this preparation was taken was a strumous boy, æt. 18, who was admitted into the Middlesex Hospital, the 27th of December, 1864, under the care of Mr. De Morgan, with suppurating glands at the angle of the lower jaw on the right side. He improved under treatment, but on the 1st of February was attacked by

sore throat. His tonsils became enlarged and studded with yellow patches; there was swelling under the lower jaw on both sides of the neck, great difficulty in swallowing, and intense frontal headache; the enlargement of the glands in the neck increased. On the 4th of February a small patch of ulceration was seen at the back of the pharynx. On the 6th of February the patient appeared better; the swelling of the neck diminished, and the difficulty of swallowing became less.

On the 9th of February ulceration at the back of the pharynx was observed to have slightly extended towards the left side. On the 10th, about midnight, the patient, who had continued to improve, had a fit of coughing, and suddenly ejected from his mouth large quantities of arterial blood, which flowed out in profuse gushes. The house-surgeon, Mr. Smith, immediately applied pressure to the carotids, and found that compression of the left had no effect on the hæmorrhage, while compression of the right at once stopped it. He accordingly at once cut down upon and tied the right common carotid, immediately above the omo-hyoid muscle. There was no recurrence of the hæmorrhage, but the patient did not rally, and died five hours after the operation.

On *post-mortem* examination, I found both tonsils enlarged, especially the right, and their follicles dilated, but there was no ulceration; the back of the fauces was reddened, but not ulcerated. Above the level of the soft palate was a small ragged opening in the middle of the posterior wall of the pharynx. This led into an irregular cavity two or three inches in diameter, situated behind and rather to the left of the pharynx. There was no distinct lining membrane to the cavity, but it was bounded by the surrounding muscles and cellular tissue, and contained a little loose black clot. There was no pus in it or near it. When water was injected into the *left* internal carotid, it filled the cavity and escaped through the opening into the pharynx.

In the left internal carotid there is, as may be seen in the preparation, a perforation forming an oval opening, the long diameter of which is three lines; it is situated rather less than half an inch below the entrance of the artery into the carotid canal in the temporal bone; the edges are somewhat thickened and everted. In the artery below this, and in the common carotid, are several small atheromatous patches, covered by the lining membrane of the artery. There were two or three similar patches, but not so numerous, in the right carotid, and

also in the arch of the aorta. The arteries at the base of the brain were normal. There was no disease of the other organs, with the exception of several patches of recent pulmonary apoplexy. The trachea too contained a good deal of frothy blood, and there was a good deal of dark blood in the stomach. The glands in the neck were enlarged, but there were no sinuses burrowing beneath the fascia.

It seems clear that in this case there must have been ulceration of the internal carotid artery, probably having its origin in an atheromatous patch. Perforation took place, and a false aneurism was formed behind the pharynx, which in a very short time ulcerated through, and the fatal hæmorrhage occurred. The reason why ligature of the *right* carotid stopped the hæmorrhage was probably this: the false aneurism behind and to the left of the trachea compressed the internal carotid below the seat of the perforation, and consequently the hæmorrhage took place from a downward flow of blood through the upper part of the artery, the supply coming from the right carotid through the anterior cerebral and anterior communicating arteries. It is probable that the attack of sore throat was a coincidence, or it may have been caused by the formation of the false aneurism. The ulceration observed at the back of the pharynx during life, was very superficial, and I did not observe any traces of it, except some reddening of the mucous membrane, after death.

Dr. William Cayley, 21*st of March*, 1865.

---

17. *Coagulum in the pulmonary artery occurring after a natural labour.*

Sarah D., æt. 45, married, was confined of her first child in the lying-in ward of King's College Hospital, under Dr. Priestley, on the 31st of January, 1865. There was nothing unusual about the labour, and she went on very well till the fifth day after delivery, when she became rather eccentric in manner, and seven days later was decidedly maniacal. On the morning of the thirteenth day after delivery she was seized suddenly with severe collapse, resembling that of cholera; the face, lips, and extremities became blue, and she passed into a state of syncope, from which she was roused for a time by the administration of stimulants. She soon relapsed into a semi-conscious condition, and died the same evening. Shortly after the accession of the attack of collapse, it was found that the left leg was œdematous and swollen,

and very painful and tender to the touch, and the left femoral artery below a spot two inches from Poupart's ligament, and the left popliteal and dorsalis pedis arteries could not be felt to pulsate. The pulse was about 130, and the respirations 38.

On *post-mortem* examination, it was found that there was recent and intense peritonitis. The femoral veins and the other large veins of both legs were filled with dark-coloured soft clots. The coagula in the veins of the left leg were if anything rather larger than those in the right leg, but the difference in size was not very marked. No clots were found in the large arteries of either leg. The left ventricle of the heart contained fluid blood, and in the aortic arch was a very small pale clot. The pulmonary artery contained an extremely large firm clot, which extended into the right ventricle on the one hand, and into minute ramifications of both branches of the pulmonary artery on the other. This coagulum adhered firmly to the curtains and tendinous cords of the tricuspid valve, but not to the arterial wall. It was quite solid, and nearly colourless in the large trunks. No indication of any impacted thrombus, which might have acted as a nucleus for the larger clot, could be found at the pulmonary bifurcation. The uterus contained a fibrous tumour as large as a small apple.

The coagulum in the pulmonary artery was no doubt formed during life, and the sudden attack of collapse was probably connected with it in some way or other. If this was the case, the symptoms could not have arisen from a sudden detachment or loosening of this large clot, as it was very firmly adherent to the tricuspid valve, and was not hollow. Neither can they be explained by the detachment of a thrombus in a distant vessel and the precipitation of fibrin upon it subsequently to its impaction in the pulmonary artery, for no trace of such primary thrombus existed in the clot. Possibly from the presence in the blood of some morbid matter absorbed into it from the uterus, or from some other cause, the blood was in a state prone to coagulate. Then the symptoms may have arisen in one of two ways. Firstly, a sudden coagulation of the blood may have been induced in the smaller branches of the pulmonary artery. The impediment thus suddenly created to the circulation would be sufficient to cause the extreme collapse, while the great retardation of the velocity of the blood current in the pulmonary artery would favour gradual coagulation of the fibrin of the blood detained there. The larger branches of the pulmonary artery being uppermost in the supine position of the body, the corpuscles would gravitate into the smaller branches, and thus a large pale

clot would be formed, which must have gradually increased in size, and by obstructing the artery more and more, ultimately caused the death of the patient. Or, secondly, threads of fibrin may have twined themselves about the chordæ tendineæ and the edges of the tricuspid valve, just as we see fibrin coagulate round a twig moved briskly about in blood recently drawn from the body. A thread of fibrin once formed, it would gradually creep into the arterial branches, and ultimately insinuate itself into their finer ramifications. Then an acceleration of the stream of blood, such as would be caused by slight bodily exertion, might at any time snap transversely some of the finer threads. These would immediately be driven into smaller branches of the artery, and the same results would then ensue as were accounted for by a sudden coagulation of the blood. Neither theory, however, explains why the left leg only should have been œdematous and not the right leg. Dr. Morris Tonge, 21*st of March*, 1865.

---

18. *Case of bony deposit in the mitral valve, with contraction of the orifice, associated with congenital malformation.*

H. C., a small, delicate little man, æt. 29, pale and flabby, was admitted into Hospital the 4th of January, 1865. He was then experiencing an attack of bronchitis of a low type and suffered much from dyspnœa and cough. On examination, loud râles were heard throughout the chest, which was, anteriorly, rather abnormally resonant. The heart's sounds were rather extended; no bruit audible then. The chest was somewhat pigeon-breasted in shape.

The history of the case showed that the man had never been in robust health—always delicate. In 1864, while serving in India, he was late one day for parade, and while running to the ground he experienced severe pain in the chest. For this ailment he was under medical treatment several weeks, and he dates the origin of his chest attacks from the occurrence of this seizure. He never suffered from rheumatism, and was a sober, steady man. After his admission for the bronchitic affection, he improved considerably under a stimulant treatment, followed by tonics, and was discharged from the Hospital on the 23rd of January, being then in the condition of health he had ordinarily experienced of late.

He was readmitted on the 27th of February, with a bronchial affection of a like nature, and on examination, a soft murmur in the locality

of the tricuspid valve, and, as far as could be determined (the heart's action being very quick and tumultuous), synchronous with the systole, was audible. The pulse was very quick and feeble, but not intermittent. His legs became œdematous; he expectorated blood in small quantity, with mucus; vomiting set in, and he sank and died on the evening of the 9th of March.

Post-mortem examination, thirty-six hours after death.—About a quart of clear serum effused in the cavity of abdomen; a small quantity in the chest.

Lungs: both congested posteriorly; the bronchi filled with mucus.

Heart, greatly enlarged; weighed seventeen ounces and a-half. It occupied a position almost transverse in the thorax, the left side uppermost. All the cavities were dilated, particularly the left auricle and ventricle; the walls of the latter hypertrophied. The orifice of the mitral valve was greatly contracted by ossified deposit, so as to admit only of the passage of a quill of large size. At first sight, being obstructed by firm coagula, it appeared as though the aperture were entirely closed.

Liver much enlarged and fatty.

Remarks.—This case is well calculated to bear out the views of Dr. Peacock relative to congenital and accidental lesions of the heart being a more frequent cause of organic disease than has been generally believed. The whole history of the case points to this conclusion. The man's delicate aspect, malposition of heart, formation of chest, and freedom from rheumatism, together with the sudden pain while on parade, are all in favour of this view. The diagnosis was rendered somewhat obscure as to the valve affected, owing to the abnormal position of the heart.

Mention has been made of the absence of a bruit on the occasion of the man's first admission and its presence when he was the second time treated in hospital. Possibly the overlapping of the lung and the abnormal position of the heart, together with the loud bronchial râles everywhere present, may have masked the murmur in the first instance; but irrespective of these agencies, cases, we know, are not unfrequently met with in which, the left auricle and ventricle being dilated, very considerable narrowing of the orifice may exist without the presence of a morbid sound.

Dr. Frederick Robinson, 21*st of March*, 1865.

19. *Heart with open foramen ovale without cyanosis.—Thickening of the pulmonary valves.*

This specimen was taken from the body of a boy, æt. $2\frac{3}{4}$, who died while being brought to St. Thomas's Hospital, on the 28th of December, 1864. His illness had only lasted a few hours, and according to the mother's account, he had not suffered from any other ailments, and had been perfectly healthy-looking, with natural colour in the cheeks. The legs and arms used to become bluish when he was cold, but not otherwise.

On examining the body, a plug of fibrinous exudation was found nearly filling the larynx, this having evidently been the cause of death. On examining the heart, the pulmonary valves were found to be thickened, and the foramen ovale was widely open. The following were the measurements of the valvular orifices of the heart, the circumference of each being given in English inches:—

Tricuspid orifice	2·40 inches
Mitral ,, ...	2·13 ,,
Pulmonary ,, ...	1·86 ,,
Aortic ,, ...	1·60 ,,

These numbers are slightly below the average of three cases of healthy hearts taken from children of nearly the same age, the measurements of which are given by Dr. Peacock in his *Treatise on the Weight and Measurement of the Heart*, the average of these cases being (in English inches)—tricuspid, 2·5; mitral, 2·31; pulmonary, 1·96; aortic, 1·7. Dr. J. Wale Hicks, *4th of April*, 1865.

---

20. *Aneurism of mitral valve.*

From a woman, æt. 51. She had always had good health up to ten months before death, when she had a severe attack of rheumatic fever. For the last two months only of her life she suffered from symptoms of morbus cordis, such as dyspnœa, lividity of face, and anasarca of lower extremities. During life there was a loud, harsh, systolic murmur audible at the apex of the heart and at the angle of the left scapula.

The mitral valve is healthy at its attached and free borders, as are also the chordæ tendineæ; but in the centre of the large cusp is a circular aperture, half-an-inch in diameter, leading into a sac which

projects into the auricle and is formed by the dilatation of the layer of endocardium on the auricular aspect of the valve; the ventricular layer appears to cease just within the margin of the aperture. The tumour, of conical shape, is seated obliquely upon the auricular surface of the valve. Its longest side, that next the free edge of the valve, measures one inch and a-quarter; the shortest, that next the attached border, three-quarters of an inch. Its diameter at the base, where it bulges a little, is also three-quarters of an inch. At the apex is an aperture about a-quarter of an inch in diameter, with an irregularly outlined fringed margin. There is a second minute orifice on one side, midway between base and apex. On the side of the auricle, at a point corresponding to the apex of the sac, is a white patch, closely resembling the "attrition" variety of milk spots on the pericardium. In the recent state the cavity was filled with coagula, partly dark and soft, partly firm, yellowish, and laminated, the same, on a small scale, as those found in the sac of an aneurism. Both apertures, but especially the auricular, are fringed with fibrinous vegetations. The free border of the aortic valves is slightly thickened, and in one there is a small round aperture almost in the situation of the corpus Arantii.

Weight of heart thirteen ounces.

Dr. Andrew, *4th of April*, 1865.

---

21. *Obliteration of the inferior vena cava.*

The vena cava inferior exhibited, was obtained from a woman, æt. 35, who died in St. Bartholomew's Hospital, with epithelioma of the cervix uteri, and amyloid degeneration of spleen, liver, kidneys, and of the small arteries of the intestines.

The cavity of the vessel is completely obliterated for about one inch from a point just below the entrance of the right renal vein. The left renal vein is impervious, the blood from that kidney having been returned partly by a vein passing up into the left supra-renal capsule, but principally by a large vessel passing downwards and backwards to join a venous plexus on the sides of the vertebræ, by means of which the blood from the lower part of the body appeared to have reached the vena azygos, which was of unusual size. The obstruction was due to an organized clot, the vein being converted into a fibrous cord.

The date at which the obstruction had occurred could not be ascer-

tained. She had had an attack of dropsy about ten months before death, from which she recovered. The feet and legs were swollen for the last two months of life, but there was no enlargement of the superficial veins of the trunk.

Dr. Andrew, *4th of April*, 1865.

---

22. *Embolism of the iliac, femoral and other arteries, and thrombosis of the femoral and popliteal veins, from a case of typhus fever, complicated with œdema and gangrene of the lower extremities.*

Eliza W., æt. 45, was admitted into the London Fever Hospital, the 8th of March, 1865, on account of a very severe attack of typhus fever, dating from the 1st of the month. The pulse was 136, and feeble; the rash was copious and petechial; the face dusky; there was extreme restlessness and delirium, with tremors, subsultus, involuntary passage of the urine and fæces, and general hyperæsthesia of the surface of the body. There was also a considerable amount of bronchitis and hypostatic congestion of the lungs. On the 17th of March the patient was obviously better; the pulse had fallen to 116; the rash had disappeared; there was a marked improvement in the cerebral symptoms, and the appetite was returning. But on the same day the patient complained of severe pains shooting down the left thigh and leg, and on the following day the entire limb was found to be swollen and of a dusky tint, and extremely tender along the course of the femoral vessels and in the popliteal space. The swelling of the limb gradually increased, and on the 24th of March the left lower extremity was twice the size of the right; the whole of the left leg was very livid, and as cold as a piece of dead flesh. There were also patches of blue lividity several inches in diameter above the knee, and the veins on the dorsum of the left foot were unusually tortuous and varicose. No pulsation could be felt in the left femoral artery. The pulsation was distinct in the right femoral artery, and the right leg was free from swelling and of natural temperature. The pulse was 156; no abnormal sound could be heard over the heart. The patient suffered extreme pain in the left leg, and was at the same time very restless and excitable, so that she required large doses of opium to procure sleep and keep her quiet.

On the 31st of March the toes of the right foot were noted as cold and livid.

April 3rd.—Numerous large vesications have formed over the left leg, some of which have burst. The coldness and lividity now reach to four or five inches above the left knee.

April 9th.—Has been sinking for the last four days; mind wandering; diarrhœa and frequent vomiting. The lividity and coldness now reach as high as the left groin. For the last three days no pulsation has been felt in the right femoral artery; the right leg has been cold and dusky, with large patches of deep lividity, but not at all swollen. At 3 P.M. the patient died, on the forty-first day from the commencement of her illness, and on the twenty-fourth day of the secondary affection of the legs. The treatment for the latter consisted, in the first place, of warm fomentations, and afterwards of enveloping the limb in cotton wool, together with tonics and stimulants, and large and repeated doses of opium.

Post-mortem examination.—The muscles, and the whole of the soft tissues of the left thigh and leg, were infiltrated with a firm exudation, nowhere yielding serum or breaking down into pus. The common and external iliac arteries of both sides, the left internal iliac artery, the whole of the left common femoral, and the upper one inch and a-half of the right common femoral were distended with coagulum, and presented the appearance of large, round, rigid cords. The vessels on the left side, however, were larger and more rounded and rigid than those on the right. On slitting up these vessels, they were found to be filled with a firm coagulum, dark in the centre, but decolorized and firmly adherent at the circumference. The coats of the vessels were brightly injected and rigid. The coagulum was much more firmly adherent on the left side than on the right. The superficial femoral, and even the popliteal artery on the left side, though not distended with coagulum, had their coats much thickened, and on slitting them up, their inner surface was found lined with a layer of adherent fibrin which could be peeled off. The same condition existed in a less degree in the right femoral artery for about two inches below the coagulum. The lower two inches of the abdominal aorta contained a firm decolorized coagulum tapering upwards to a point, continuous below with the coagula in the common iliac arteries, but not adherent to the coats of the aorta. Above this the aorta was healthy, with the exception of a few small patches of atheroma immediately above the aortic valves. The muscular tissue and valves of the heart were healthy. The left ventricle contained several masses of firm decolorized fibrin slightly adherent.

The spleen contained two firm, pale masses, about the size of chestnuts like those ordinarily attributed to embolism.

The right renal artery presented the appearance of a rigid cord, and on slitting it up, it was found filled with coagulum, pale and firmly adherent at its circumference. The corresponding kidney was large, pale, and firm, and contained extensive masses of recent inter-tubular deposit like those resulting from embolism. The left renal artery was patent, and the left kidney healthy.

The left femoral and popliteal veins were distended with coagulum, dark in the centre, but pale and adherent at the circumference. This condition did not extend to the iliac vein, nor were any of the veins of the right limb similarly affected.

There was extensive hypostatic hyperæmia of both lungs, and the bronchial tubes were gorged with frothy mucus.

Remarks.—This case was one of unusual interest. Œdema of the leg and gangrene of the feet are not very uncommon sequelæ of typhus fever, but it is very rare that they are found occurring in the same case. Œdema of the leg, resembling the "white leg" of puerperal women, can in many cases be traced to obstruction from plugging of the femoral vein. It is a remarkable circumstance that it is almost invariably the left lower limb which is affected. Except that it retards recovery, this complication is rarely of a serious character; the patients almost always recover. Gangrene of the feet, on the other hand, is generally believed to result from obstruction by plugging of the main arteries of the limb, and, although it is still a subject for investigation whether some of the instances of gangrene of the toes, of the nose, or of the penis, occurring in the course of typhus fever, are due to arterial obstruction, this view of the matter is confirmed by the present case. The existence of a layer of fibrin adhering to the inner surface of the arteries for some distance below the obstructing coagulum, and the condition of the spleen and right kidney, are points worthy of attention. It is also to be noted that though gangrene had commenced in both legs, swelling was confined to the limb in which the vein was obstructed. A valuable memoir, by Dr. Patry, on *Gangrene of the Limbs in Enteric Fever* will be found in the *Archives Générales de Médecine* for February and May, 1863.

Dr. Murchison, 18*th of April*, 1865.

23. *Aneurism of the aorta, with rupture into the right ventricle of the heart.*

The specimen which I intend showing to the Society is that of a patient who was under my treatment at the German Hospital. He was admitted on the 6th of January with a severe accident to his left arm, necessitating instant amputation in the upper third. The patient was apparently of a good constitution, æt. 29. The case progressed as favourably as possible, and had it not been for a delay in the detachment of the ligatures, by which circumstance the wound was prevented from closing entirely, he would have been discharged most probably a fortnight before his death. On the 12th of February, however, according to these notes, for which I am indebted to Dr. Lutz, one of our resident medical officers, the patient, whom I had seen only the day before to all appearance in perfect health, suddenly complained of severe palpitation of the heart. On the following day, when I saw him again, the pulse was 128; temperature 38. 2°. Cent. A frémissement cataire was perceptible to the touch at the lower region of the heart, and each sound was replaced by a strong bruit, principally at the base of the heart, and at the left margin of the sternum. The patient felt sick, and on the previous day vomiting had taken place. The countenance of the patient showed signs of severe dyspnœa, the colour being of a grey, unearthly hue.

These symptoms continued more or less the same up to the 17th instant, on which day the thermometer placed in the arm-pit showed no signs of fever, and the second sound of the heart was very indistinctly heard. The patient, on the whole, appeared to improve, at least with regard to his previous distressed feelings, up to the 23rd instant, when, besides his increased dyspnœa, he complained of severe pain over the left lobe of the liver. On the 25th the urine showed for the first time slight traces of albumen; dyspnœa and bruit both increased; severe vomiting set in afresh; towards evening sudden collapse, and at 1 A.M. on the 26th the patient died.

Post-mortem examination thirty-one hours after death. Thorax.—Pericardium not adherent, containing not more than the usual amount of transparent fluid. Under the visceral layer of the pericardium numerous blood-extravasations, varying from the size of a pin's head to that of a small pea, at many parts of the heart.

Heart, very flabby, of light yellow colour; right ventricle dilated, not hypertrophied; right auricle dilated; right auriculo-ventricular

opening much dilated, diameter being 4.5 centimeters, by 3 centimeters. Each flap of the tricuspid valve shortened; at that point where the anterior and posterior flaps unite they are bordering on a small sac-like protuberance of the size of a filbert, which bulges into the right auriculo-ventricular opening. At two places especially prominent and pointed, the walls of the empty sac are very thin and transparent, and at one point ruptured, the rupture itself measuring about 3 millimeters; the margins are fringed.

The pulmonary artery dilated, measuring just above the valves 8 centimeters, the aorta being merely 6.3 centimeters.

Left ventricle not dilated, the walls tolerably thick, measuring at the lower part 1.7 centimeter, at the upper 2 centimeters. The mitral valve, with the exception of a slight opaqueness, is normal. The aortic valves somewhat thickened, of a gelatinous appearance, but closing perfectly. Behind the posterior semi-lunar valve, close to its place of insertion, may be seen a round smooth aperture of the size of a goose-quill, which opens into the sac above mentioned, the aperture being closed by the flapping of the semi-lunar valves against the wall of the aorta. The heart was easily torn, showing to the naked eye, as well as microscopically, fatty degeneration. Aorta not dilated; at some parts a commencement of atheromatous deposits. The heart contained a small quantity of clotted blood, the aneurism none whatever.

In both pleural sacs clear serum was found. The lungs at the apices œdematous, at the lower parts compressed.

Abdomen contained a considerable quantity of a transparent yellow serum, mixed with some gelatinous flakes; the intestines not glued together.

Liver of nutmeg appearance, with fatty degeneration, old cicatrices, and commencing cirrhosis.

Kidneys flabby, and containing much fat.

With regard to the previous history of the case, I should mention that the patient himself stated that he had been in the enjoyment of constant good health; but upon inquiring of his wife, I heard that he had been suffering from occasional palpitations of the heart, accompanied by shortness of breath attendant upon any slight extra exertion, and that within the last few months he had been seized upon two different occasions with severe fits, the exact nature of which I am unable to explain.

The case above mentioned has, besides its general importance, one or two features of great interest, which, according to my opinion, are well

worth being noticed. When I saw the patient on the 13th of February, the day after his having been attacked with the severe disturbance in the action of the heart, Dr. Baeumler and Dr. Lutz, who watched the patient with me, as well as myself, thought we had a case of endocarditis,—especially of the aortic valves,—before us. In the first instance, the idea struck me that it might have something to do with the previous amputation; but after maturer consideration, I was obliged to give up this idea, for there were several links of the chain wanting to refer it to that cause: there had been, for instance, no rigor, a symptom with which pyæmia generally, if not always, sets in. The patient, besides, had been quite well from the 6th of January up to the 12th of February, and the wound, almost healed, had at that date a healthy appearance.

The following *post-mortem* examination certainly set that scruple entirely at rest, for the stump was found upon examination in a very satisfactory state. With regard to the supposed endocarditis, I mentioned that on the 13th of February the mercury of the thermometer placed in the axilla rose only to 38.2° cent., this being the highest point it ever reached, viz.: 1.2° above the range of normal temperature, and on the 17th inst., as the report states, the patient was without fever, altogether a strange circumstance for a fresh case of endocarditis with such severe disturbance in the general circulation. We therefore thought it much more likely that the patient had been suffering formerly from a valvular disease hitherto unnoticed by us, but now by some circumstance or another producing the severe symptoms above mentioned.

After having thus given a short sketch of the history of the case, I, lastly, beg to draw attention to the most interesting feature of it. The specimen itself will show that, during the systole of the left ventricle, the opening into the aneurism was entirely closed by one of the valves of the aorta being applied against it, whilst during the diastole a part of the blood of the aorta was forced through the then uncovered opening into the aneurism, and this having burst into the right ventricle, arterial blood became thus mixed with venous blood. With regard to the phenomena of auscultation, the case presented the same symptoms as are found in aortic regurgitation.

Dr. Lichtenberg, 18*th of April*, 1865.

---

24. *Aneurism of the aorta.*

G. O., æt. 25, admitted into King's College Hospital under Dr.

Johnson, on the 22nd of March, 1865. Always short-winded and liable to palpitations. Never had rheumatic fever. Dropsy came on a month ago.

He has a peculiar loud, shrill cough, which occurs only when he is on his back. The heart's action is tumultuous and the impulse strong.

At the base there is a shrill bellows-sound heard with systole, and a musical cooing sound with diastole. The carotids pulsate strongly. Pulse 120, full and collapsing.

On the 25th of March he suddenly became worse, and died, with symptoms of syncope, about 10.30 A.M. He was treated with iron, quinine, and acids.

Post-mortem examination, thirty hours after death.—The pericardium was much distended with fluid. Heart large; weight twenty-two ounces; all the cavities filled with clots.

The aorta was much dilated and diseased, and a large pouch from it projected behind the pulmonary artery, pressing upon it. The posterior pulmonary valve was adherent to the wall of the vessel along its whole length, and at its base, where the walls were exceedingly thin, was a perforation connecting the pulmonary artery with the aortic pouch, which, however, was possibly made during the *post-mortem* examination. Just above the perforation was an ecchymosed spot as big as a shilling.

Abdominal viscera natural.

Dr. JULIUS POLLOCK, 18*th of April*, 1865.

---

25. *Cases of cancerous deposit in the heart.*

It has been generally supposed that the heart is very rarely the seat of cancerous deposits, and but few examples of the occurrence are recorded by the older writers on pathological anatomy and on cardiac affections.

Corvisart does not relate any instance of the kind, though alluding to the occurrence of hydatids in the organ. Laennec states that he had seen two instances of encephaloid deposit in the heart, and that Récamier had mentioned to him a case of scirrhus. Andral and Bayle, in a special memoir published in 1824,* speak of the rarity of such affections, and record only three cases which had fallen under their notice; and Bertin, writing in the same year, refers only to the

* *Revue Médicale*, 1824, T 1rl, p. 268.

cases which they had met with. Since that time, with the more general cultivation of morbid anatomy, a larger number of cases have been placed on record. Bouillaud, in the first edition of his work, published in 1835, refers to fourteen cases, though some of them are very imperfectly reported, and it may be doubted whether all are instances of true cancer. In 1839, Dr. Hope stated that the number of cases on record was about a dozen, but he does not mention having himself met with any. In 1844, Dr. Walshe says that he found no difficulty in bringing together twenty-five cases from different sources, and I have, without any very extended search, collected forty-four cases more or less fully reported, and references to several others. Of these, sixteen are recorded in our own *Transactions*, and seven in the *Bulletins* of the Societé Anatomique, of Paris. The defective clinical history of the cases, however, referred to by Dr. Walshe, is still to be regretted, though most of the recently reported cases are more satisfactory in this respect.

In the following paper, I propose to relate the particulars of two cases which have recently occurred at the Victoria Park Hospital, in which the heart was the seat of cancerous deposits, and to offer a brief notice of the features of similar cases which have been recorded.

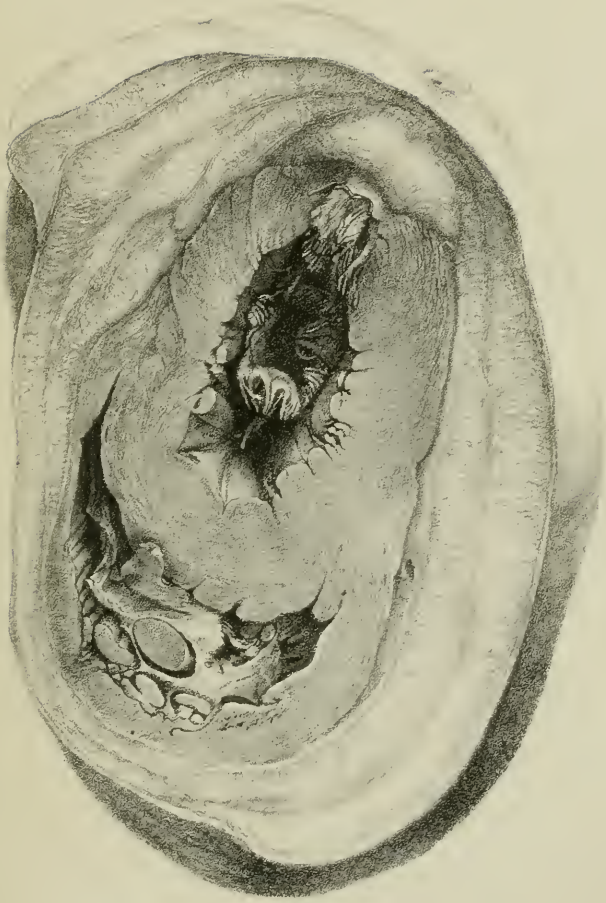
Case I.—For the notes from which the following abstract has been made, I am indebted to Dr. Lanchester, now of Croydon, who was the resident medical officer at the Victoria Park Hospital at the time the case occurred.

M. W., æt. 18, a grocer's assistant, was admitted into the Victoria Park Hospital, under the care of Dr. Peacock, on the 29th of April, 1863. He stated that he had been first taken ill in October of the previous year, and that his indisposition commenced with diarrhœa, which occasioned great prostration of strength; and he continued poorly till Christmas. In the beginning of 1863 he was taken worse, and continued to become weaker till his admission into the Hospital. He then complained of cough and expectoration, and the sputum was occasionally streaked with blood. He was very sallow, the conjunctivæ displayed an icteroid tinging, the liver was enlarged and he was much prostrated. No marked signs of disease in the chest were detected. He stated that his father had died of cancer of the heart; but his mother was living and there was no history of phthisical predisposition. He had never had any serious illness,

DESCRIPTION OF PLATE V.

The plate illustrates Dr. Peacock's case of Cancerous Deposit in the Heart (Case I., p. 100).

The heart is shown as divided transversely about its middle, and in the section the muscular substance is seen to be completely embraced by the cancerous mass.



F. Burgess lith. ad nat.

W. West imp.

except an attack of fever nine years before, and had enjoyed fair health till the commencement of his present symptoms. He was considerably emaciated; his breathing was hurried, and he had a troublesome cough and considerable expectoration of frothy mucus. The pulse was quick and feeble, 120 in the minute, the tongue coated but moist, the bowels acted regularly; the urine was high coloured, alkaline, and slightly albuminous, but did not contain casts: specific gravity, 1.027. He slept pretty well, and lay partly on his right side and partly on the back.

The left side of the chest was fuller than the right, and especially low down. The resonance on percussion was defective everywhere on the left side, and there was entire dulness at the lower part. Respiration was imperfectly heard over a large portion of the left side but was absent below, and the respiratory sounds at the right apex were harsh. The heart occupied its usual position, and its sounds were natural. The liver was greatly enlarged, extending from the level of the fifth rib to an inch and a-half below the cartilages. Subsequently the urine became more albuminous, and there was considerable œdema of the lower extremities, involving the integuments of the abdomen and thorax. The dulness on percussion at the lower part of the left side extended, and the heart became somewhat displaced to the right. His breathing was so laboured that he was incapable of occupying the recumbent position. He had several attacks of diarrhœa, became much weaker, and died on the 1st of June.

The heart's sounds were latterly feeble, and the pulse scarcely perceptible at the wrist, but there was never any morbid murmur. He was a stout built lad, with a heavy face; but there was not any œdema of the face or upper extremities or obvious distention of the veins.

The body was somewhat emaciated; there was general anasarca involving the parietes of the abdomen and thorax, and the lower extremities. The lungs were closely adherent to the ribs on both sides, and the attachments were so firm that they were with difficulty removed. There was a cavity at the lower part of the left pleura containing about half a-pint of fluid. The left lung weighed thirty-three ounces, and contained several large masses of cancerous deposit, with others of small size, closely resembling ordinary tubercle, at the apex. The right lung was congested, and also contained some deposits, both infiltrated and of large size, but less than the left; it weighed thirty-seven ounces and a-half. The bronchial glands were extensively diseased, being converted into white medullary sarco-

matous tumours, which surrounded the bronchi, large vessels, and œsophagus, and involved the lungs. The heart was completely embraced by a cancerous mass fully an inch in thickness, which compressed the auricles and the large vessels at the base. The two layers of pericardium were thus entirely adherent, but the muscular structure of the ventricles was apparently not involved in the disease. (Plate V.)

The liver contained several small cancerous tumours, some as large as walnuts; similar deposits existed in the gastro-hepatic omentum, and several were found in the spleen.

The kidneys were granular, but did not display any appearance of cancer. In the lower portion of the ileum several of the plates of Peyer were the seat of small deposits, and in two or three there was superficial ulceration, the whole closely resembling phthisical disease. The mesenteric glands also were cancerous; but the œsophagus, stomach, supra-renal bodies, bladder, and prostate were healthy.

The deposits in different parts of the body displayed the usual characters of encephaloid.

Case II.—E. T., æt. 19, a servant, was admitted into the Victoria Park Hospital, under the care of Dr. Ward, on the 11th of January, 1865. She stated that she had been ill for six months, and that her attack had commenced with pain in the left side, followed by cough, some spitting of blood, and night perspirations. When admitted, the difficulty of breathing was extreme, so that she was incapable of lying down; and she had a severe cough, with copious expectoration, partly frothy, partly purulent. The respirations were rapid, 40 in the minute; the pulse feeble, irregular, very rapid,—144. The whole of the left side of the chest was dull on percussion, and the vocal thrill was abolished; some rhonchus was audible at the left apex. Her face was sallow and her lips livid. Shortly after her admission, she complained of pain in the region of the heart, and the sounds of the heart were muffled and the action unduly powerful; subsequently a soft systolic murmur was heard. The sputum became tinged with blood. There was never any marked enlargement of the superficial veins of the upper part of the body or œdema of any part. She became weaker, and died on the 22nd of January.

The left lung was everywhere attached to the parietes and to the pericardium, and on cutting into it several large cavities were laid open, containing a considerable quantity of thick, creamy pus. The substance of the lung was the seat of white, soft, cancerous

deposits, which occupied a large portion of its structure, and had in places, especially towards the base, softened, breaking up extensively the lung tissue. The cancerous masses had apparently originated in the mediastinum or bronchial glands, and had thence involved the lung. Some of the glands were however unaffected and retained their usual black colour, though entirely embedded in the medullary sarcomatous mass. The pericardium was much pressed upon by the cancerous tumours, and within its sac there were two large masses which involved and compressed the auricles and the descending cava and pulmonary veins. Some portions also projected into the auricles and destroyed the muscular structure.

The pericardium contained about an ounce of greenish turbid fluid. The parietal layer was much congested in patches, and the anterior surface of the heart displayed a patch of recent lymph about an inch in length.

The right lung, though engorged, was crepitant and entirely free from deposit. The stomach and duodenum were surrounded by enlarged glands which displayed the cancerous structure; but the liver, spleen, uterus and ovaries, and intestines, were free from disease. The kidneys were somewhat mottled, and one of them displayed a cyst; but both were otherwise healthy. The deposits had the usual appearances of medullary cancer.

Remarks.—The cases which I have collected, including the two here narrated, amount to forty-five in number, exclusive of several others referred to by different writers, though too imperfectly reported to admit of analysis. These cases may be classed into four series.

I. Cases of primary cancer, or in which the disease existed only in some portion of the heart. Cases of this kind are evidently of very rare occurrence. I am able to refer only to two instances in which the heart was the seat of carcinomatous deposits and the other organs and parts of the body are expressly stated to have been free from disease. In seven other cases, however, no mention is made of the existence of similar disease in other parts of the system, some of these being very imperfectly reported.

Of the cases of primary cancer in which the other organs are stated to have been free from disease, in one, a female 46 years of age, the muscular fibres of the lower part of the right ventricle were found converted into a whitish yellow material having all the characters of encephaloid; in the other, a boy of 12, the walls of the right ventricle

and a large portion of those of the left consisted of a lardaceous material of the nature of medullary cancer. The only portions unaffected were the septa.

II. In a second series of cases, the heart appears to have been affected by cancer in conjunction with other parts of the body, and especially of the adjacent organs,—the bronchial or mediastinal glands or lungs. Cases of this kind afford generally very marked examples of the cancerous diathesis, the disease appearing in several different parts, and apparently almost simultaneously. Of this form of disease the Table contains five cases, one of them being the first which I have myself related. In a sixth case also, the disease may either have occurred coincidentally in the heart and the abdominal organs, or the affection of the former may have been consecutive to that of the latter part.

III. In the third series of cases the cancerous disease occurs in the parts adjacent to the heart, the bronchial or mediastinal glands, the lungs, or the glands around the larynx and in the neck, and spreads by contiguity, so as to involve the pericardium and the large vessels at the base of the heart or the auricles. In the Table, eight cases of this description are referred to; but this form of disease is probably of comparatively common occurrence, there being but few cases of cancer in those situations in which the parts about the heart are not in some degree involved. In a case of cancer of the bronchial glands and lung recorded by myself in a former volume of the *Transactions* and not included in this calculation, this condition existed.

IV. The fourth series of cases includes those in which the cancerous affection of the heart is secondary to disease in some other part of the body. Cases of this description are certainly by far more common than either of the others—of the forty-five tabulated instances, twenty-one being cases of secondary cancer. The heart may be thus affected as a sequence of disease originally developed in some distant part of the system. Thus I find that the original seats of disease were in

3 cases, the eye,
1, the cheek and bones of the face,
1, the lower lip,
2, the breast and axillary glands,
1, the radius of fore-arm,
1, the ribs and pleura,
7, the abdominal organs,
1, the inguinal glands,
1, the uterus and vagina,

1, the labium and clitoris,
1, the glans penis and inguinal glands,
1, the testicle, and in
1, the thigh.

Nature and extent of disease.—The precise kind of cancerous disease of which the heart was the seat is not mentioned in eight of the cases, it being simply stated that the heart and other organs were affected by cancer. In the remaining thirty-seven cases, the disease is said to have assumed the form of scirrhus in seven cases; of melanosis in four cases; and of encephaloid in twenty-five cases; and in one the primary disease appears to have been melanotic and the secondary encephaloid.

Of the cases of scirrhus, in one the disease extended to the heart from the adjacent organs, in five it was secondary to disease in other parts, and in one the state of other organs is not reported.

In all the cases of melanosis the disease was secondary—in two instances to disease of the eye, in one of the axilla, and in one of the lungs and bronchial glands.

Of the cases of encephaloid, in two the disease was primary; in three the existence of disease in any other part of the body is not named; in six it extended to the heart from the adjacent parts, and in fourteen it was secondary.

The mode and extent in which the disease involved the heart varied considerably in different cases. In those in which the disease spread by contiguity, there was generally some affection of the pericardium, or the heart and large vessels were compressed by the tumours. The disease assumed the form of cancerous infiltration in five instances; in some of these cases a large portion of the auricles and ventricles were extensively degenerated, so that in one it is stated that there was not more than one-twelfth of the organ free from the deposit, while in others smaller portions only were so affected. The degree to which the structure was involved also differed; the muscular structure being in the affected parts wholly destroyed in some instances, and much less extensively diseased in others. In fourteen cases, in which the heart was the seat of isolated masses, the disease was generally secondary. The masses varied considerably both in size and number; frequently they are compared to peas or beans, more rarely to almonds or chestnuts, and still more rarely to hens' eggs or oranges. In some cases they were only one, two, or three in number; in others they were more numerous, a dozen being mentioned in one instance; and in another

case it is said that the examiner ceased counting when he had enumerated six hundred small deposits in different parts of the heart.

In the case related in the paper and in one reported by Dr. Bright, the heart was completely enveloped in a mass of medullary sarcomatous matter, and the reflected pericardium was entirely attached to the heart by the deposit.

The parts of the heart affected also varied in different cases. Generally it appears that in cases of secondary deposits the right auricle or ventricle was the seat of disease, either alone or in conjunction with the left auricle and ventricle. The deposits were generally situated beneath the attached pericardium, more rarely beneath the endocardium, and still more rarely in the substance of the auricles or ventricles or of the inter-ventricular septum. In some cases they formed tumours projecting into the large systemic or pulmonary veins or into the auricles and ventricles, and in one or two cases pressing upon the cardiac apertures, so as to interfere with the action of the valves. In one case the disease affected the semilunar valve only, and in another a single mass of cancer existed near one of the coronary arteries at the origin of the aorta.

The disease is only asserted to have advanced to the stage of ulceration in one case, that of the semilunar valve, in which there is said to have been an ulcerated passage behind the valve. In this instance, however, the nature of the disease may be open to doubt. In the case of the tumour external to the origin of the aorta, the mass softened, and so led to the destruction of the arterial coats and the escape of blood into the cavity of the pericardium. In another case, reported as cancer by different writers, there is said to have been an ulcerated mass on the surface of the heart; but the true nature of the disease in this instance is very doubtful—indeed I have not enumerated it among the cases of cancer contained in the Table.*

Symptoms and duration.—In by far the largest proportion of cases, whether the disease of the adjacent organs was diagnosed or not, there were no symptoms which indicated the affection of the heart, and the condition of the organ was only detected on *post-mortem* examination.

In some instances, however, where the disease extended from adjacent parts, there were evidences of pressure on the venous trunks during life,—distension of the veins of the neck, upper extremities and thorax, or œdema of these parts, and, more rarely, murmurs were detected indicating obstruction to the flow of blood from the heart. In some cases also, the small masses deposited on the surface of the

* The case of Carcassone.

heart gave rise to irritation and inflammation of the pericardium, the existence of which was recognized during life by the usual signs. Two cases of this kind have fallen under my own notice and others are on record. In yet other instances, the symptoms of which were imperfectly noted during life, the pericardium is stated to have been adherent, indicating the existence of adhesive pericarditis at a more or less distant period.

In one of the cases just detailed, though the existence of a tumour in the chest was very clearly ascertained a considerable period before the death of the patient, and the statement that the patient's father had died of cancer of the heart directed attention to the condition of that organ, no symptoms specially indicating the heart to have been involved were detected. It is indeed probable, that in most cases, and especially where the heart is the seat of a secondary deposit, the affection of the heart exercises but little influence over the progress of the carcinomatous disease in other parts of the system.

In twenty-one cases, the actual duration of illness from the first occurrence of disease in any part of the system to the death of the patient is recorded in the notes. Of these, I find that in five cases in which cancer probably manifested itself simultaneously in different parts, the duration of illness was five weeks, six weeks, ten weeks, four months, and nine months. In five cases in which the heart was involved in the growth of cancerous tumours of adjacent parts, the patients survived ten weeks, and three, six, seven, and twelve months. And in eleven cases, in which the cardiac disease was secondary to cancer in other organs, the patients lived, after the appearance of disease in the part first affected, six weeks, three and a-half, five, six (two cases), and nine months, one year, sixteen and eighteen months, two years, three years, and six years.

In the cases of primary cancer, the duration of the disease is not capable of being ascertained; one patient died suddenly of apoplexy from the extravasation of blood into the tuber annulare, and the previous history was not known. In the other, the patient had had pleurisy and pericarditis, from which he had completely recovered, except suffering occasionally from vertigo; and he died suddenly.

REFERENCES TO PUBLISHED CASES OF CANCER OF THE HEART.

Author, References, and Date.	Age.	Sex.	History and Symptoms.	Form of Disease, Primary or Secondary.	Other parts affected.	Duration of Disease, Cause of Death, &c.
1. Path. Trans., vol. i., 1846-47, 1847-48, p. 42, Dr. C. J. B. Williams.	46	M	Intemperate; three years before, the right eye was extirpated for bleeding tumour; this was followed by hemiplegia of left side, and he became epileptic; the disease subsequently recurred in the eyelid, and the lower extremities were paralyzed	Melanotic deposits in heart. Secondary to melanosis of eye	Encephaloid mass adhered to spinal theca, over sixth dorsal vertebra, and there was caries of the bones; the abdominal integuments, liver, and pancreas were similarly affected	Duration upwards of 3 years
2. Ibid, p. 193, Mr. Moore, in patient of Dr. Hawkins, at the Middlesex Hospital.	55	F	Last illness commenced with dyspnœa, cough, and expectoration; tortuous veins appeared on neck, arms, and in epigastrium and on thorax; sputum tinged with blood; œdema of arm, and gangrene after amputation	Pericardium, auricles, vena cava, and pulmonary veins involved in tumours of bronchial glands and root of lungs. Encephaloid	Encephaloid disease of bronchial glands and root of right lung, involving substance of lung; left lung healthy	Duration about 10 weeks
3. Ibid, p. 281, Mr. Smith.	35	M	Melanotic tumour of eyeball, extirpated 6 weeks before death; followed by symptoms resembling angina pectoris, and pain in the head	Mass in the substance of the left ventricle, size of a chestnut, and others near it. Melanotic. Secondary to affection of eye	Two masses, the size of garden peas, at the origins of the second pair of nerves; masses also in peritoneum, liver, and kidneys	Total duration, 6 weeks
4. Ibid, vol. iv., 1852-53, p. 39, Mr. Hutchinson, St. Bartholomew's.	33	M	Painful swelling at left side of jaw, and bone removed; recurrence of disease, and ulceration of the cicatrix; occasional stitches, and slight difficulty of breathing	A single "pea-sized" nodule, projecting from the lining membrane of the right ventricle. Encephaloid. Secondary to affection of cheek	Ulcer of neck and cheek, and affection of the glands; cancerous nodules on pleura, and especially on surface of the diaphragm; no affection of abdominal organs	1 year

Author, References, and Date.	Age.	Sex.	History and Symptoms.	Form of Disease, Primary or Secondary.	Other parts affected.	Duration of Disease, Cause of Death, &c.
5. Ibid, vol. vi., 1854-55, p. 112, Dr. Wilks.	33	M	Intemperate; engorgement of thoracic and abdominal veins; excessive dyspnœa and lividity; sounds of heart feeble; right side of chest dull on percussion, and evidences of pressure on vena cava descendens; right side of chest unusually dull; no œdema of lower extremities	Tumour pressing on the base of the heart and large vessels, and protruding into cavities of pericardium and auricles, and on descending cava and pulmonary veins. Encephaloid. Extended from bronchial glands to mediastinum	Right lung, and bronchial and mediastinal glands entirely converted into masses of medullary cancer; no affection of cervical or other glands, or other part of system	Died a few days after being seen
6. Ibid, p. 324, Dr. Sanderson, in patient of Dr. Alderson, at St. Mary's.	43	F	Commenced with excessive paroxysmal pain in forehead and occiput, with vomiting and prostration of strength; the pain in the head ceased before death; great failure of muscular powers; no loss of intelligence or sensation, or paralysis of extremities; there was dysphagia, and the pulse became excessively feeble	Melanotic tumours on the surface of the right ventricle, and also on the surface and in the interior of the left ventricle; the masses were less than, or about the size of, peas. Coincident occurrence of cancer in different organs	Melanotic masses in thorax, opposite first and second dorsal vertebræ; also in the right lung, behind the peritoneum, and in the liver and pancreas; deposits also in the mammary glands, and external to the right lobe of the cerebellum, and in other glands	Total duration about 10 weeks. Perhaps secondary to mammary cancer
7. Ibid, vol. vii., 1855-56, p. 386, Mr. H. Thompson.	25	M	Testicle removed 5 months before death, for disease originating in injury, and consisting of a combination of cholesteatoma, enchondroma, and encephaloma	Mass as large as a filbert embedded in walls of heart, and projecting into cavity of right auricle. Encephaloid. Secondary to disease of testis	Enlarged glands in course of iliac vessels, and deposits in lumbar glands, liver, and both lungs	—

Author, References, and Date.	Age.	Sex.	History and Symptoms.	Form of Disease, Primary or Secondary.	Other parts affected.	Duration of Disease, Cause of Death, &c.
8. Ibid, pp. 47 and 387, Dr. Bristowe, in patient of Dr. Barker, St. Thomas's Museum, x. 67.	16	M	An engineer, previously in good health; symptoms of extensive effusion in right pleural cavity	Walls of ventricles and auricles infiltrated with cancerous matter, but without distinct tumours. Medullary affection of anterior mediastinum, lungs, and heart probably coincident	Cancerous masses in anterior mediastinum; very small deposits, probably of similar nature, on right lungs; kidneys also infiltrated with white medullary deposits, and mesenteric glands similarly affected	Whole duration of illness, 5 weeks
9. Ibid, vol. viii., 1856-57, p. 337, Dr. Peacock and Dr. Bristowe.	55	M	Symptoms of chronic affection of the chest, with gradually advancing emaciation	Mass as large as a pea in posterior wall of right auricle, and a second as large as a bean. Medullary. Probably secondary to abdominal cancer, and to deposits in lungs	Cancer of ribs, and masses in pleura and lungs; also in kidneys and supra-renal bodies	6 months, total duration of illness
10. Ibid, vol. ix., 1857-58, p. 29, Dr. Pitman and Mr. Holmes.	23	M	A marine; spitting of blood, dysphagia, loss of voice, cough and expectoration; dyspnœa; lividity; tumour at right side of sternum; systolic murmur heard over tumour and at base of heart; pulse full and bounding	Pericardium firmly adherent, and several large tumours projecting from the right ventricle, and pressing on right auriculo-ventricular aperture, and upon large vessels at base. Encephaloid. Affection of bronchial glands, involving heart	Tumour of well-marked encephaloid structure at right side of sternum, and destroying the bone; lungs also extensively involved	Duration, 7 months
11. Ibid, p. 87, Dr. Wilks.	—	M	Not stated	Three or four cancerous nodules, the largest about the size of peas, in the substance of the right ventricle. Secondary to the disease in the other organs	Cancer in lungs, stomach, liver, &c.	—

Author, References, and Date.	Age.	Sex.	History and Symptoms.	Form of Disease, Primary or Secondary.	Other parts affected.	Duration of Disease, Cause of Death, &c.
12. Ibid, p. 128, Mr. Sibley for Mr. Shaw.	45	F	Commenced with cancer of the right labium and clitoris, which was apparently scirrhus, and became well marked and was removed; soon reappeared, and the glands in the groin became affected; symptoms of adhesive phlebitis of leg then appeared	Small deposits of scirrhus cancer beneath the endocardium of the right auricle and ventricle, with fibrinous deposits on them. Secondary to cancer of labium and clitoris	Cancer of right labium and glands of groin; lungs healthy, but fluid in pleura; adhesive phlebitis of veins in different parts of body	18 months; obstructive phlebitis and endocarditis
13. Ibid, vol. xi., 1859-60, p. 78, Dr. Fuller.	60	M	Cough, bloody expectoration, dyspnœa, and dulness on percussion on the right side of the chest; action of heart regular but impulse weak, rapid; afterwards, action slower, and slight systolic murmur audible over the whole præcordia; anasarca, and albuminous urine	Right auricle with cancerous infiltration, entirely destroying structure, and forming tumours passing into cavity of right auricle and left ventricle; right pulmonary artery passed through the tumour; the presence of disease could not be detected on the right side. Encephaloid. Extended from mass at root of lung	Hard encephaloid mass at root of lung	3 months
14. Ibid, vol. xiv., 1862-63, p. 240, Dr. Dickinson.	70	M	Cancer of glans penis, involving groin, and followed by small tumours in different parts of the integuments of trunk and extremities; short hacking cough	Nodule, size of a sixpence, on anterior surface of heart. Encephaloid. Secondary to glans penis and glands of groin and abdomen	Bronchial glands enlarged; penis, and inguinal and other glands affected; also bladder, kidneys, omentum, liver, and spleen; lungs healthy	Survived about $3\frac{1}{2}$ months from commencement of disease
15. Ibid, p. 246, Mr. Bryant.	30	M	Melanotic tumour of right axilla, and small tumours in abdominal walls, the sequence	Tumour the size of a marble embedded in walls of right ventricle. Partly melanotic.	Mass size of chestnut in left hemisphere of brain, and others in lungs and	Duration upwards of 2 years

Author, References, and Date.	Age.	Sex.	History and Symptoms.	Form of Disease, Primary or Secondary.	Other parts affected.	Duration of Disease, Cause of Death, &c.
			of a mole in epigastrium, which had been excised; dry cough, with pneumonic expectoration, but no head symptoms	Secondary to tumour of axilla and integuments	bronchial and mediastinal glands; pigmental cancer also of lumbar and mesenteric glands, bladder, and kidneys, liver, and spleen; one kidney healthy	
16.* Andral Path. Anat. by Townsend and West, Dublin, 1831, vol. ii., p. 344.	56	M	Symptoms of aneurism of the heart	Whole walls of right ventricle and auricle converted into hard, dirty white coloured substance, and possessing all the characters of encephaloid	Not stated	—
17.* Ibid.	37	M	Asthma, and subject to attacks of excruciating pain in the region of the heart; angina pectoris, and afterwards dyspnœa, palpitation, and vomiting; attacks of short duration; no evidence of disease of heart or lungs; œdema	Knotted encephaloid tumour in external wall of right ventricle, which projected externally, and appeared like a supernumerary heart; some parts hard and some soft	Not stated	Died suddenly
18. Cruveilhier, Essai sur l'Anat. Path., Paris, 1816, vol. i., pp. 86, 87.	Old	M	Commenced with scirrhus of the breast, involving the axillary glands, muscles, and bones	Many scirrhous tumours on the heart and in the substance of its walls. Secondary to affection of breast and axilla, &c.	Scirrhous tumours in the chest, abdomen, arm, and thigh, and tubercles under the skin; the lungs were full of masses; the brain was not examined	In the account of this case, it is stated that Dupuytren had seen a heart so charged with cancerous deposits, that the person making the

* The above two cases are quoted in the "Memoire sur le Cancer du Cœur," par MM. Andral and Bayle, published in the 'Revue Médicale Française et Etrangère' et 'Journal de Clinique de l'Hotel Dieu et de la Charité de Paris.' 1824. T. i., p. 268.

Author, References, and Date.	Age.	Sex.	History and Symptoms.	Form of Disease, Primary or Secondary.	Other parts affected.	Duration of Disease, Cause of Death, &c.
						examination stopped counting when he had enumerated 600
19. Rullier, Bullet. de la Fac. de Méd., 1813, No. 5, t. iii., p. 357.	35	M	Subject to frequent attacks of inflammation of lungs, and taken after one with pain in the left side, oppression at the chest, and pain and swelling in the abdomen; always lay on the left side; œdema of lower extremities	Nearly whole heart converted into scirrhus, with scanty traces of natural structure, and with masses projecting in places, both externally and internally, not more than 1-12th of the muscular structure remaining. ? Secondary to abdominal affection	Pancreas, omentum, and mesentery, and alimentary canal from the stomach to the lower part of ileum, extensively carcinomatous; the lungs sound	—
20. Billard, Traité des Mal. des Enfans nouveaux-nès. Paris, 1828, p. 647.	3	M	No history	Hard masses on anterior surface of heart, called scirrhus	Not stated	—
21. Path. Trans., vol. xiv., 1862-63, p. 40, Dr. Peacock in a patient of Dr. Edwards.	31	M	Swelling on left lower costal cartilages, entire dulness on left side, absence of respiration except down left side of spine, vocal vibration feebly felt, intercostal spaces not obliterated; two weeks before death a pericarditic friction sound was heard	Nodules of encephaloid deposit under endocardium, and attached pericardium, with recent lymph from pericarditis. ? Secondary to affection of abdominal organs	Carcinomatous deposits on pleura and left lung, and in coats of intestines, gall-bladder, kidneys; one suprarenal capsule entirely destroyed, the other considerably involved	Entire duration of illness, 9 months

Author, References, and Date.	Age.	Sex.	History and Symptoms.	Form of Disease, Primary or Secondary.	Other parts affected.	Duration of Disease. Cause of Death, &c.
22. Med. Chir. Trans., vol. xxii. 1839, p. 15, Dr. Bright.	17	F	Commenced with pain in right knee and foot, followed by swelling of glands of groin and neck, and over ischium; these symptoms were succeeded by severe dyspnœa, and a tumour was detected in abdomen	Heart and pericardium glued together by a thick layer of yellow malignant matter, right phrenic nerve was almost embedded in it. Coincident to lung affection	There was a mass of white fungoid matter in the anterior mediastinum, chiefly attached to the heart; the right lung also contained deposits, and the glands in course of iliac vessels, and in abdomen and mesentery, and the ovaries and broad ligaments were extensively affected with fungoid disease in the cerebriform and hæmatoid forms	4 months
23. Path. Trans., vol. xvi., p. 102, Dr. Peacock in case of Dr. Ward.	19	F	Symptoms of consolidation on right side; pulse feeble, quick, and irregular	Encephaloid tumours pressing on each auricle and entrance of vena cava desc., and on pulmonary veins. Encephaloid tumour at root of lungs, involving heart	Tumour at root of lung, and in substance of lungs, with deposits also in stomach and duodenum, and glands of mesentery	6 months
24. Ibid, p. 101, Dr. Peacock.	19	M	F. died of cancer of the heart; commenced with hepatic symptoms, and when admitted was slightly jaundiced, respiration hurried, cough and expectoration which had been bloody; signs of consolidation on left side; heart somewhat displaced; pulse quick and very feeble; œdema of chest, abdomen, and lower extremities	Pericardium entirely adherent, and cancerous matter involving both membranes, and entirely embracing heart and surrounding large vessels at base. Encephaloid. Coincident to cancer in bronchial glands, and lungs and other organs	Small interspersed deposits, resembling tubercle, in lungs; bronchial glands carcinomatous; cancerous masses in gastro-hepatic omentum, and mesenteric glands; ulceration and deposit in intestinal mucous glands, and in liver and spleen	9 months

Author, References, and Date.	Age.	Sex.	History and Symptoms.	Form of Disease, Primary or Secondary.	Other parts affected.	Duration of Disease, Cause of Death, &c.
25. Bulletin de la Soc. Anat. de Paris, viime année, 1832, p. 53, M. Sestie in a patient of M. Dumeril's.	55	F	Tumours of neck, affecting the larynx and trachea, followed by congestion and œdema of face, and of upper extremities, and afterwards symptoms of asphyxia	The right auricle and vena cava superior involved in a cancerous mass; hard, scirrhoid	Thyroid body, cervical ganglions, and lungs displaying cancerous masses	—
26. Ibid, xvime année, 1841, p. 266, M. Tardieu.	69	F	Tumour in right flank, great dyspnœa, and death by asphyxia	A tumour on the anterior surface of the right ventricle. Secondary to affection of kidneys and abdomen	Numerous encephaloid tumours in the right kidney, and also in left kidney, liver, and lungs	—
27. Ibid, xxime année, p. 167, M. Bourdon in a patient of M. Fouquier.	—	—	Loss of flesh, and pain in epigastrium, followed by a tumour there; pulse quick, hard but regular; palpitation; respiration laboured, and expectoration of mucus; died exhausted	Pericarditic adhesions and effusion, and cancerous masses in the ventricles of the heart. Encephaloid. Secondary to the abdominal affections	Tumour in the spleen, liver, gastro-hepatic omentum and mesentery; also in lungs	5 months
28. Ibid, xxvme année, 1850, p. 253, M. Broca in reference to a case of M. Destouches, cancer of aorta preceding rupture	29	M	Sudden death when labouring under albuminuria, and blood found effused into the pericardiac sac	Tear in the coats of the aorta, a centimètre above the origin of the anterior coronary artery; this found to be due to a tumour between the pericardium and the coats of the artery, the size of a small hen's egg, and this shown to be cancerous on microscopic exa-	Not named	—

Author, References, and Date.	Age.	Sex.	History and Symptoms.	Form of Disease, Primary or Secondary.	Other parts affected.	Duration of Disease, Cause of Death, &c.
				mination; the aperture had been forced through the cancerous mass		
29. Ibid, xxvi^{me} année, 1851, p. 64.	—	—	Commenced with swelling of the inguinal glands, a year and a-half before death	Masses in the interior of the right ventricle, and one of them was pedunculated, and projected into the right auriculo-ventricular aperture. Encephaloid, proved by microscopic examination. Secondary to affection of inguinal glands	Many masses were contained in the lungs, but none in bones, liver, or kidneys	—
30. Ibid, xxviii^{me} année, 1853, p. 4.	33	F	Extreme dyspnœa and distension of veins of upper extremities and upper part of trunk; pulse scarcely to be felt; dulness on right side of chest	Masses contained in ventricles, not obvious externally, and only detected on section. ? Coincident affection of bronchial glands and lungs and abdominal organs	Lungs full of cancerous masses, which invaded pericardium and bronchial glands; also in mesenteric and abdominal glands, and in both kidneys; not in other abdominal organs	6 weeks
31. Ibid, xxiv^{me} année, p. 108, M. Campana, Lariboisiere.	62	F	Ulcerated cancer of the vagina and uterus, and signs of organic affection of the heart; œdema of the lower extremities; smallness and irregularity of pulse, and superficial friction sound, masking the sounds of the heart; respirations slow, only 12 in the minute	Large masses in the walls of right ventricle, both pointing externally, and projecting into the cavity; several smaller masses in the right auricle. Encephaloid; character confirmed by microscopic examination. Secondary to cancer of vagina and uterus	Disseminated cancerous masses in the inguinal glands and coats of bladder; deposits in pleura and lungs, but not in other organs	—

Author, References, and Date.	Age.	Sex.	History and Symptoms.	Form of Disease, Primary or Secondary.	Other parts affected.	Duration of Disease, Cause of Death, &c.
32. Bouillaud sur les Mal. du Cœur, iime éd., 1841, t. ii., p. 431.*	—	M	Died in a state of imbecility *	Portions of the heart were converted into a lardaceous substance in places, with little remains of the natural structure; it was very hard and thick, and surrounded especially the auricles and auriculo-ventricular apertures; the septum was affected, but the ventricles were sound	Not stated	Imperfectly reported
33. Ollivier, Traité des Mal. de la Moelle Epinière, iiime éd., 1837, t. ii., p. 164.	46	F	Admitted into the Salpêtrière with hemiplegia of right side of several years' duration; died apoplectic two days after; no symptoms of cardiac disease	The fibres of the lower part of the right ventricle changed into a whitish-yellow material, having the ordinary characteristics of encephaloid. Primary	Lower parts of both lungs engorged with blood, but no cancerous disease in any other part of system	Died 2 days after admission, of extravasation into tuber annulare and left peduncle
34. Bertin, Bouillaud, ibid, p. 433.	45 to 50	F	After an illness of five or six months, died with symptoms of chronic peritonitis	Two masses of cerebriform cancer in the right and left ventricles; one the size of an almond, the other less. Probably secondary to the disease in the abdomen	Numerous small masses in the peritoneum and glands, mesentery, and omentum, around the gall bladder and in the liver	Ill 6 months
35. Revue Médicale Française et Etrangère, par J. B. Cayal,	—	M	A soldier, at home on leave from Algeria; admitted into Hospital with swelling of the legs, followed by symptoms of heart disease; pulse small,	Cancer of the semilunar valves of the aorta, in front of the origin of the posterior coronary artery; valve four times its natural thickness,	Not stated	—

* ? Obs. 2nd of Andral and Bayles' Memoir.

Author, References, and Date.	Age.	Sex.	History and Symptoms.	Form of Disease, Primary or Secondary.	Other parts affected.	Duration of Disease, Cause of Death, &c.
1841, t. ivme p. 203, case by M. Payan.			hard, quick, and irregular, but not intermittent; lividity, "bruit de râpe," and "fremissement" in the region of the heart	reddish coloured, and readily lacerable; there was ulceration behind its base, and the disease was obviously cancerous		
36. Cruveilhier, Liv. xxix., pl. 2, case of M. Hudellet.	34	M	Tumour of thyroid, involving larynx	Tumour involved the right auricle and descending cava	—	—
37. Rayer, Traité des Mal. des Reins, t. iii., p. 709, case of M. Lerminier, in 1831.	—	—	—	Cancerous mass in the heart	Cancer of kidneys, vertebræ, &c.	—
38. Lond. Med. and Phys. Journal, vol. lvii. (N. S., vol. ii.), 1827, p. 280, case quoted by Dr. Churchill from Reports of Med. Soc. of Tours.	36	F	Had a tumour on the forearm six years before death, which was extirpated by Dupuytren, and some time after the disease reappeared, and was again removed by M. Dubois; three years after, pain again appeared in the seat, and patient died with symptoms of suffocation; cough, &c., and	About a dozen small, hard cancerous masses in the heart, and deposits also in the interior of the vena cava and auricles, and causing obliteration of the lower part of aorta. Scirrhus. Secondary to tumour of the arm	Scirrhous deposits in the radius, thyroid gland, and thigh; also between the ribs and pleura, and in the stomach, duodenum, liver, gall-bladder, pancreas, omentum, kidneys, and dura mater	This is the case which is the subject of M. A. Velpeau's memoir, entitled "Exposition d'un cas remarquable de Maladie Cancéreuse." Paris, 1825

Author, References, and Date.	Age.	Sex.	History and Symptoms.	Form of Disease, Primary or Secondary.	Other parts affected.	Duration of Disease, Cause of Death, &c.
			paralysis and swelling of lower extremities			
39. Med. Chir. Trans., vol. xviii., 1833, Sims on Malignant Tumours connected with the Heart and Lungs, case 2nd, p. 285.	43	M	Illness commenced with hæmoptysis, followed by cough and expectoration, and pain in the chest, dyspnœa, swelling of the face, &c.	Tumour at base of lung, involving vessels and auricles, and projecting in places internally; of different characters, partly hard, partly soft and fluctuating. Encephaloid. Extending from tumour at base of lung	Tumour of right side of chest, involving bronchial glands and right lung, and pressing on bronchi and vessels	Total duration of illness, about 12 months
40. Med. Gazette, Jan., 1834, Coates in case at St. Bartholomew's Hospital.	—	M A Spanish refugee	Commenced with cancer of lower lip, which ulcerated and was extirpated six months after its first appearance; it reappeared in the cicatrix, and involved the bones and glands of face and neck	Scirrhous masses in right auricle and ventricle, size of one or two peas, and also in left auricle, and deposits occupying upper two-thirds of left ventricle. Secondary to disease of lower lip	Common tubercles of phthisis and cavities at the upper parts of both lungs; scirrhous tubercles in the liver; other organs healthy	Total duration of disease 16 months, and death 10 months after the operation on lip
41. Museum of St. Thomas's Hospital, x., 64.	—	—	Commenced with a cancerous tumour of the thigh	Encephaloid tumour of the size and shape of a large orange, in the inter-ventricular septum, projecting into the right ventricle; another, the size of a filbert, hanging into the right auricle; and others projecting into the pulmonary veins. Secondary to the disease in the thigh	Cancerous masses also in the thigh, lung, and brain	—

Author, References, and Date.	Age.	Sex.	History and Symptoms.	Form of Disease, Primary or Secondary.	Other parts affected.	Duration of Disease, Cause of Death, &c.
42. Ibid, x., 65.	—	—	—	Small encephaloid tumour attached to the inner surface of the right auricle, and another in the auricular appendage	—	—
43. Ibid, x., 66.	—	—	—	Several small tumours on surface of heart, beneath the pericardium. Secondary to affection of the rib. Encephaloid	Cancer of rib, brain, skin, supra-renal capsules, spleen, &c.	—
44. Ibid, x., 67.	—	—	Melanosis of eye	Several small melanotic tumours in the substance of the heart. Secondary to disease of eye	Melanotic masses in peritoneum, omentum, pancreas, kidneys; pleura of diaphragm and submaxillary gland	—
45. Revue Médicale, t. iv., 1825, p. 247, M. Segalas in the notice of the proceedings of the Ac. Royale de Médicine.	12	M	The child had had pleurisy and pericarditis, after which he enjoyed good health, only suffered from vertigo and weakness; he had no symptoms of serious disease of the heart, but died suddenly	Pericardium adherent; heart a third larger than natural; all the right ventricle, and a great part of the left, converted into lardaceous substance of the nature of medullary cancer, the interauricular and ventricular septa alone being entire. Encephaloid. Primary	No other disease mentioned, and, it may be inferred, existed, except some arachnoidal effusion and mucus in the bronchial tubes	—

26. *Ulcerated cavity in the wall of the heart. Death from meningitis.*

John M. æt. 35, was admitted into the London Fever Hospital, March 24th, 1865. He was very thin, and he stated that he had suffered from cough, but had never spat blood. His mind was confused, so that he was unable to give any connected account of his present illness. On admission: pulse 104; heart's sounds normal; respirations oppressed; slight dulness and loud harsh breathing at apices of both lungs; skin hot; no eruption; tongue dry and brown; bowels open, not loose; looks very ill, but makes no complaint of pain; no paralysis; pupils equal, of moderate size. On the night of March 25th, the patient became actively delirious, and on the following day he was much worse; pulse 132; respirations 48, and noisy; sonorous and moist râles heard all over chest; heart's sounds normal; has low muttering delirium, and is very heavy and drowsy, so as to be roused with difficulty; tongue dry and brown, and teeth covered with sordes; bowels open. On March 27th, he was still lower; involuntary stools and urine; right pupil of medium size, left widely dilated and inactive: expression vacant, but excited; swallows with difficulty. Died the same evening.

Post-mortem examination.—The whole surface of both hemispheres, and of the greater part of the base of the brain, was coated with recent, solid lymph, which lay beneath the arachnoid and dipped down with the pia mater between the convolutions; but nowhere could any trace of tubercle be discovered. There was no recent tubercle in the lungs, but both apices were adherent, and contained old cicatricial tissue. The bronchial tubes of both lungs contained much frothy mucus. The valves of the heart were competent, but in the wall of the left ventricle, immediately below the attached margin of the aortic valve which lay next the septum, was a cavity the size of a filbert communicating with the interior of the ventricle by an opening large enough to admit a goose-quill, and containing a grumous substance, like blood mixed with pus and fragments of fibrin. There was very extensive atheroma of the aorta.

Remarks.—This case was remarkable both in a clinical and in a pathological point of view. It was at first regarded as an example of acute tuberculosis supervening upon chronic phthisis, and the existence of meningitis was not suspected until the day of the patient's death. The pathology of the meningitis is also an important subject for consideration in the case. Although occurring in a tubercular subject, it really appeared to be independent of tubercular deposit, so that the question

arises, whether it had a pyæmic origin, or was due to contamination of the blood by the matters thrown off from the ulcerated cavity communicating with the left ventricle of the heart.

Dr. Murchison, 16*th of May*, 1865.

---

27. *Case of ruptured aneurism of the heart.*

J. N., a tailor by trade, had led a more than ordinarily sedentary life in consequence of his having become crippled by disease of the hip-joint at the age of nine years. On the 24th of April, he was engaged in completing a heavy piece of work, and in the morning he remarked to his wife that it "would finish him." He ate his dinner as usual, and three hours later, while seated on his board, he fell forward, gave several snoring inspirations, and expired in less than five minutes, without having uttered a word. His wife reported, that from an early period of life he had been subject to palpitation of the heart, and latterly to fainting fits. A feeling of exhaustion was common to him, and to obviate this he was in the habit of taking food at short intervals. He had however avoided stimulants, indeed had been almost a tectotaller. Four weeks ago, an unusually severe attack of syncope had been accompanied by sharp pain in the chest, described as in the situation of the heart, and this was felt at times subsequently. He objected to take any medical advice.

During the last three months of his life, it was observed that he micturated frequently, and at times there was incontinence. For a shorter period he had been subject to relaxed bowels, and also to headache.

I assisted at the examination, twenty-four hours after death. The body was in good condition, much blanched, and there was no œdema. The right hip-joint was anchylosed.

The pericardium was distended by a coagulum; probably eight ounces of blood had escaped; there was no serum. The seat of the rupture was at once discovered to be in the left ventricle. About midway between the base and apex, and rather nearer to the posterior than to the anterior margin of the inter-ventricular septum, a flaccid pouch projected, at the central and most prominent part of which was a jagged rent half an inch in length. Its direction was vertical from base to apex, and occurred in the line of the left cardiac vein. This vein when inflated ceased to be pervious a short distance from the seat of the rupture. Beneath the pericardial investment of the heart, in this situation, were some small ecchymosed spots. The membrane itself was healthy. A large quantity of fat covered the right ventricle and the

the inter-ventricular groove. The walls of the heart were flaccid and uncontracted; both auricles and ventricles were empty. The wall of the left ventricle near the apex was of normal thickness. The muscular tissue was of a dull colour and rather greasy. The transverse muscular striæ were generally well marked; in a few instances some aggregated granules were seen beneath the sarcolemma.

The thining of the left ventricle at the diseased part took place abruptly. The wall of the pouch was reduced to the thickness of brown paper, and was devoid of true muscular tissue. Under the microscope fibrous tissue, with some granules and nuclei were alone visible. The cavity was the size of a pigeon's egg, and was lined with irregular and discoloured coagulum, beneath which the endocardium was continuous, and appeared natural. One of the columnæ carneæ was ruptured. The several valves were healthy, with the exception of slight atheromatous thickening; some semi-detached plates of atheroma were seen in the arch of the aorta. Both coronary arteries were much stiffened by disease, that portion of the left coronary which went to supply the diseased portion of the ventricle particularly so. It was, however, pervious.

With the exception of the kidneys, the other organs of the body, including the brain, were healthy. Both the former organs were small, the surface was furrowed, the capsule was adherent and split into layers, and when removed the granular condition was evident; the cortical substance was of diminished thickness.

Dr. Bagshawe, 16*th of May*, 1865.

---

28. *Thoracic aneurism, involving the arteria innominata and arch of the aorta.*

The sac of the aneurism was opened on its upper and anterior aspect in removing the sternum, as it was strongly adherent to the *manubrium*, on the posterior surface of which destructive caries had commenced. The upper half of the left lung was the seat of pneumonia, and the right lung was greatly congested.

The aorta was opened from below upwards; its inner coat was studded with atheromatous deposit, which was most abundant in the course of the arch. A fibrinous clot was found, commencing in the left ventricle, and extending upwards continuously into the aneurismal sac, and also for some little distance along the arch of the aorta. The aortic valves were healthy, as was also the mitral valve. The walls of the left

ventricle were much hypertrophied. A large fibrinous clot was found in the right ventricle, which extended for about an inch into the pulmonary artery; the pulmonary and tricuspid valves were normal.

The subject of this aneurism was brought into the 'Dreadnought,' suffering from acute dyspnœa, with cough and slight mucous expectoration. The pulse numbered 120. There was a loud diastolic bruit, heard most clearly at the apex of the heart, with loud tracheal and bronchial wheezing, and a very audible respiratory murmur over both lungs before and behind.

This patient died four days after admission, and no history as to the cause and duration of the disease could be obtained.

A great many cases of thoracic and abdominal aneurism come to the 'Dreadnought,' and a distinct history of injury (as exciting cause) is made out in most cases. The great exertions made whilst leaning bodily over the yards in reefing, hauling at ropes, and lifting heavy weights, are among the chief causes producing aneurismal dilatation in sailors.

Popliteal aneurism appears to be very rare with this class of men, only one case having entered the 'Dreadnought' for many years.

Mr. Harry Leach, 16*th of May*, 1865.

IV.—DISEASES, ETC., OF THE ORGANS OF DIGESTION.

A. STOMACH AND INTESTINES.

1. *Intestines from a case of typhus fever complicated with diarrhœa.*

John S., æt. 44, was admitted into the Fever Hospital, on August 31st, 1864, on the ninth day of an attack of typhus fever. The typhus rash was well marked, the tongue dry and brown, and the bowels relaxed. On September 4th (thirteenth day) the pulse had fallen to 84, and the rash was fading, but the diarrhœa was obstinate, the motions being liquid and of a dark brown colour. This diarrhœa resisted all treatment, the man became gradually weaker, and died on September 9th, on the eighteenth day from the commencement of his illness.

Post-mortem examination.—The intestines were carefully examined. Neither Peyer's patches nor the solitary glands of the ileum were enlarged, and there was not the slightest trace of congestion or ulceration in any part either of the small or large bowel. The spleen and liver were of normal size. There was considerable congestion of the dependent parts of both lungs.

Remarks.—It is a mistake to imagine, as is sometimes done, that every case of continued fever complicated with diarrhœa must necessarily be enteric fever. Diarrhœa, in fact, has been a very common complication of true typhus during the present epidemic; but in every such case, where I have had an opportunity of examining the intestines after death, they have presented the negative characters observed in the case now recorded, or at most they were only slightly congested. In some of the cases, no doubt, the diarrhœa had been induced in the first place by the incautious administration of purgatives, but this explanation would certainly not apply to all of the cases.

Dr. Murchison, 18*th of October*, 1864.

---

2. *Intestines of a child who died of enteric fever at the age of* 6 *months.*

The child had died in the Fever Hospital after a febrile attack, with diarrhœa, of a fortnight's duration. She had no well marked spots; but her mother, who was a patient in the Hospital at the same time, had a typical attack of enteric fever, including the eruption. Peyer's patches in the lower part of the ileum were elevated and ulcerated. There was no thickening or deposit at the edges or base of the ulcers. The mesenteric glands were slightly enlarged.

Dr. Murchison, 18*th of October*, 1864.

---

3. *Poisoning by butter of antimony (chloride of antimony.)*

The case occurred in the practice of Mr. Hopewell, of Chelsea, with whom Dr. Crisp examined the body. The subject of the case was a girl æt. 19, who, in consequence of mental disturbance, swallowed three ounces of the above-named substance. The poison was taken at one o'clock in the afternoon, and the patient died about the same time on the following day(twenty-four hours). The prominent symptoms were excessive pain in the region of the stomach, great anxiety of countenance, excessive thirst and vomiting, commencing about six hours after the poison was taken, and diarrhœa coming on a few hours before death. Little or no urine was passed, and the intellectual faculties were unimpaired. A short time before death there was slight *subsultus tendinum;* the lips and mouth were black and excoriated, as was the œsophagus; the stomach was uniformly covered with the chloride of antimony, of which about two ounces were collected. On removing this, the lining membrane of the stomach was seen, black and charred,

the submucous tissue being of a reddish hue; the small intestine, to the extent of about two feet from the pylorus, was of a dark colour, and the lining membrane was readily detached. Nothing abnormal was observed in the appearance of the other thoracic and abdominal viscera. The brain was not examined.

Dr. Crisp said that examples of poisoning by chloride of antimony were very rare. Taylor, in his work on poisons, mentioned only four cases; one (doubtful) related by Orfila; a second in a boy ten years of age, who took a tablespoonful of chloride of antimony; a third, a boy seven years of age, who took two drachms: both the last named patients recovered. The fourth example was an army surgeon, who took two or three ounces, and died in ten hours and a-half. Diarrhœa appears not to have been present in any of these cases. In the last named case, attempts were made to evacuate the bowels, but nothing passed.

A wax model showing the recent appearance of the stomach was also exhibited. Dr. Crisp, 18*th of October*, 1864.

---

4. *Strangulation of intestine by diverticulum ilei.*

Eliza W., æt. 10, was admitted, under Dr. Wilks' care, into Guy's Hospital, suffering from symptoms of strangulation of the bowel; very shortly afterwards peritonitis came on, and she died in a few hours. The symptoms commenced ten days before death, with an attack of sickness attributed to eating some indigestible fruit. She had never previously had any symptoms indicative of obstruction of the bowel.

The *post-mortem* examination showed acute recent peritonitis. On lifting up the abdominal wall, a band was seen passing from the umbilicus to the lower part of the ileum, to which it was attached. The portion of gut above was much distended, whilst that below was contracted; the latter, being a coil about one foot and a-half long, was hanging down towards the pelvis, thus increasing the tension of the parts. On more careful examination, the constricting band was found to be a diverticulum ilei, and was hollow from its origin at the gut to its termination as a blind end at the umbilicus. At its origin it was of the same calibre as the contracted portion of the ileum below it, and easily admitted of the passage of a glass rod as large as an ordinary lead pencil. A considerable dragging had been caused by its attachment to the ileum, and to such an extent that finally a partial separation had

taken place at its point of attachment to the ileum; thus the fatal peritonitis had been caused.

The interest of the case lay in the cause of strangulation by a congenital malformation. It is known that the diverticulum ilei is generally considered to be a remnant of the umbilical vesicle or vitelline duct; but in most cases it exists as a mere pouch, and is unimportant. In this case, as in some others recorded, it reached the umbilicus, to which it was attached; and here being firmly fixed, there was a constant drag on the ileum.

The only practical consideration arising from such a case, is to remember that in an exploratory operation in a case of obstruction, a cord passing to the umbilicus is very likely to be a diverticulum of intestine. It might also be remarked that in such cases of a permanent vitelline duct, a fæcal opening has sometimes remained after the sloughing off of the umbilical cord. Such cases now and then come before the surgeon, and are relieved by operation.

Guy's Hospital Museum contains four specimens of this malformation, where it caused an obstruction to the intestine. In one case, the patient had reached the age of forty-three. In another, a child, the patient had previously undergone a successful plastic operation for a fæcal discharge at the umbilicus.

Dr. Samuel Wilks, *15th of November*, 1864.

---

5. *Large intestine from a case of typhoid fever.*

James K., æt. 20, admitted into Guy's Hospital in an insensible state; his case was thought to be one of fever, but the diagnosis was not positive. The *post-mortem* examination showed the intestine most extensively affected by the typhoid deposit; the ileum, as usual, showed the Peyer's patches and solitary glands of large size, and affected for the length of several feet. The most remarkable appearance was presented by the large intestine, which was affected from end to end, or as far as the sigmoid flexure. The whole surface was covered with a deposit in the solitary glands, producing a number of elevations, like peas, closely set or almost in contact, and giving the appearance as if the whole mucous surface was affected by a variolous eruption. This affection of the solitary glands is often seen in the cæcum; but for the whole of the large intestine to be involved is quite an exceptional occurrence.

Dr. Samuel Wilks, *15th of November*, 1864.

---

6. *Traumatic abdominal hernia, with extensive rupture of the recti abdominis muscles, involving the left epigastric artery.*

W. A., æt. 50, a remarkably muscular and well made man, was admitted into the Great Northern Hospital, on the 18th of October, in a state of collapse and semi-consciousness. He was an engine driver on the Great Northern Railway, and, it appears, was standing on the rail in front of an engine and at some little distance from it. In order to effect some shunting, the engine was put in motion without his noticing it, by which he received a violent blow on the abdomen from the buffer, and was thrown off the rail. The engine did not go over or even touch him after the blow.

When admitted, he had a large tumour, of the size of a cocoa-nut, occupying the centre of the abdominal region. His pulse was almost imperceptible, and skin cool and clammy. In six hours after admission he began to suffer from intense pain, and to vomit, and he lay with his legs drawn up, as the easiest position. Nothing appeared to afford any relief to his symptoms, so that he sank, and died twenty hours after the accident.

The tumour was found, on *post-mortem* examination, to consist of several coils of intestine, which had passed through a rent in the abdominal muscles, five inches in length. The rent was somewhat oblique, and included the rectus muscle on the left side, with the epigastric artery, the linea alba (crossing it just below the umbilicus), and the greater portion of the rectus of the right side. The peritoneum was torn to an extent corresponding to the laceration of the muscles; but the intestines and the skin with its sub-layer of fat, were unaffected by the injury. The abdominal cavity contained a large quantity of blood; and the adjoining muscular structures were infiltrated with it to a great extent. Mr. Gay, 15*th of November*, 1864.

---

7. *Colloid cancer of peritoneum.*

The photograph from which the annexed plate is copied was taken in the *post-mortem* theatre, and subsequently exhibited to the Society by Mr. Mason, for Mr. Dillon, of Berne, Switzerland.

G. A., æt. 56, a patient under Professor Biermer in May, 1864. Has a decidedly cachectic aspect, and says that he has always enjoyed tolerably good health until two years ago, when he first noticed a

DESCRIPTION OF PLATE VI.

The plate illustrates Mr. Francis Mason's case of Colloid Disease of the Peritoneum (p. 128).

The drawing is taken from a photograph.

From Photograph. T. West. lith.

tumour within and at the lower part of the abdomen. This tumour has gradually increased in size in every direction up to the present time, and for the last three months has enlarged very rapidly. He has never had much pain in the part, and has suffered in no special manner excepting from slight dyspepsia and occasional constipation.

On examination, there is a large nodulated mass within the abdomen, extending from the diaphragm to within the pelvis. One well defined tumour, situated a little higher than the umbilicus, is supposed to be either the liver or a tumour in close connection with that organ. In each inguinal canal there is a hernia which extends to the scrotum. His appetite is good; but he experiences a sense of oppression after meals, and occasionally vomits his food. There is no pain in the part, and no œdema of the lower extremities. He continued under observation for about four months, and one morning suddenly lost consciousness and died.

Post-mortem examination twenty-four hours after death.—On opening the abdomen, about a gallon of gelatinous-looking fluid rapidly flowed away. With the exception of a loop or two of small intestine, none of the abdominal viscera were visible, the whole surface being thickly studded with semi-transparent nodular masses (*see* Plate VI.). The disease, which in some places was four or five inches in depth, extended from the diaphragm down to the pelvis, and following the course of the inguinal canal on each side, reached the bottom of the scrotum. One tumour larger than the rest, and somewhat resembling the shape of the liver, was situated in the upper part of the abdominal cavity, and no doubt produced during life the prominence already referred to as existing near the umbilicus. The whole of the abdominal contents came out *en masse*. It was with great difficulty that the liver and spleen could be detected, these viscera being entirely surrounded by, and buried in, the gelatinous mass. The viscera themselves were found perfectly normal, the disease being apparently confined to the peritoneal covering.

Several of the tumours were examined under the microscope, and were found to contain large cells of an undoubtedly cancerous nature.

Mr. Francis Mason, *20th of December*, 1864.

8. *The stomach, duodenum, and part of the jejunum of a very fat man weighing about eighteen stones.*

The case occurred in the practice of Dr. Henry Davis, of Putney.

The patient, a man, about 60 years of age, had for many years been a great eater and drinker; he suffered much from flatulence, and was in the habit of taking large quantities of aperient pills, which he procured at the shop of a druggist. Colicky pains were present in the abdomen when he was first seen, and these were followed by a low form of peritonitis, which caused his death in six days after he was first visited by Dr. Davis. There was obstinate constipation from the commencement, but not entire obstruction.

The intestines were found glued together by recent lymph, but no other mechanical obstruction was observed. The stomach and small intestines were much distended and of large capacity; the coats of the former were very thin. The length of the stomach (as measured by Dr. Crisp) was fifteen inches, its breadth when opened eleven inches. The lower part of the duodenum and of the jejunum when opened measured five inches and a-half from side to side; the kidneys were deeply embedded in fat, and this material was deposited in many other parts to an enormous extent; thus large flakes of fat were attached to the small intestines, that measured three inches in diameter. The liver was large, light coloured, and very fatty, but notwithstanding, the fæces presented a normal appearance, and the gall-bladder was filled with what appeared to be healthy bile. It was thought that the great capacity of the stomach and small intestines was due to the long continued over-feeding, the gaseous distension, and the injudicious use of aperients. Dr. Crisp, 17*th of January*, 1864.

---

9. *Post-mortem bursting of the stomach.*

The specimen was taken from the body of a young French-woman, under the following circumstances:—

She had been a lady's-maid, and was 25 years of age. She was unmarried, but became pregnant, and at the time of her death was in the fifth month. She had been in the hands of a well known and infamous quack, who it is supposed had made unsuccessful attempts to cause abortion. She left this person, and a week before her death took

poison, it is not known what, which caused continued vomiting and pain in the belly.

On November 16th she was brought to St. George's, and was placed under Dr. Page. She was haggard, and had an appearance of much distress. She was very restless, and had pain in the belly. There was constant vomiting, which was unchecked by any of the remedies used. She died nine hours after her admission.

The *post-mortem* examination was made thirty-five hours afterwards. When the peritoneal cavity was opened some gas escaped, and a quantity of thick brown fluid, afterwards found to be identical with the contents of the stomach, was pretty evenly diffused between the bowels. The intestines, and the peritoneum generally, were quite free from abnormal vascularity, and there was no trace of lymph or of any inflammatory product. It thence appeared likely that the extravasation into the peritoneum had taken place after death, and when the stomach was examined this conjecture became a certainty. The stomach was perforated by a round hole, about as large as a sixpence, in the middle of the great curvature, which had the following character:—The mucous membrane was torn for nearly two inches, exposing in its separation the areolar tissue beneath. Nearly corresponding in situation was a somewhat zigzag irregular rent in the peritoneal coat. The torn edges were somewhat separated, so as to expose the tissue underneath. Where the fissure in the peritoneum was opposite to that in the mucous membrane a thin film of areolar tissue was all that remained of the wall of the stomach. In the centre of the part thus weakened the fibres of areolar tissue had separated and made a circular perforation of the size stated. The edges were quite thin and transparent, such as would result from stretching the same structure after death. The stomach was fully dilated. There was no congestion around the hole, nor any evidence of morbid action. It was clear that the perforation had taken place after death, and it was equally evident that it had not been produced by the gastric juice, as there was no thinning of the coats, nor any change in their colour or texture. The conclusion that the stomach had been burst by extreme gaseous distension was verified by comparison with another stomach intentionally burst by the pressure of a column of water. In the latter case the peritoneal coat was extensively torn, the mucous to a less extent, and the intervening tissue least of all. The hole had exactly the same circular character as was observed in the case under consideration. The resemblance was close in every particular.

There was a patch of brown discoloration on the lower end of the œsophagus; several were in the stomach; and there were also evidences of the superficial action of a corrosive poison in the large and small intestines.

The uterus contained a fœtus of about the fourth month.

There could be no doubt in this case that the stomach had burst in consequence of the accumulation of gas within it. There were indeed some traces of corrosion in the walls, but they were very slight and did not correspond with the place of the rupture. It is not impossible that the coats might have been slightly softened by the action of the poison; if so, it was in too small a measure to be evident to the senses, and was insufficient to alter the mode of rupture, since the stomach in question was torn in exactly the same manner as the healthy stomach, which had been intentionally burst.

Dr. Dickinson, 17*th of January*, 1865.

---

10. *Two cases of enteritis.*

Case I.—A young woman was admitted, November 25th, 1864, under the care of Mr. Hewett, a month after delivery, in consequence of abscesses in the breasts. These discharged, and she went on well for about a fortnight, when she began to suffer abdominal pain, the countenance became anxious, the tongue furred, the pulse small and rapid. She then had rigors, the belly became tympanitic, and she sank eight days after the symptoms commenced.

At the *post-mortem* examination, the abscesses were seen to be healing, though they still existed in both breasts. Both pleuræ contained sero-purulent fluid, and there was a layer of recent lymph on each lung. The abscesses in the breasts were quite superficial.

In the last two feet of the small intestine the mucous membrane was converted into a yellowish-green patchy slough, and the tissues beneath were somewhat thickened. Peyer's patches belonging to the affected portion were swollen and rough. The slough was distinctly separated from the rest of the bowel, which was natural. The mesenteric glands in the neighbourhood of the affected part were red and enlarged.

Case II.—A boy, æt. 13, was admitted under the care of Dr. Fuller, on the 4th of December, 1864. For four or five months before his appetite had been ravenous; he had been losing flesh, and had had night sweats. The bowels were always regular until somewhat less than

three weeks before his admission, when he was kept from school for two days by an attack of vomiting and diarrhœa. He had no pain, but the secretions were slimy and tinged with blood. When he had apparently recovered from this attack, five days before admission, he was seized with pain in the belly, some swelling in the same region, and difficulty in passing water. He afterwards had one or two distinct rigors.

When under observation, he had a pinched, anxious face, suggestive of abdominal disease. Between the umbilicus and the pubes a resisting mass was felt, somewhat globular in shape, only so prominent as to be visible on careful inspection. It was not very tender. The skin was warm; the pulse 120, of fair strength; the tongue moist and much furred. He was ordered to have an oil enema, which brought away a yellow, loose secretion, and a pill of calomel and opium was given every four hours. Next day he vomited all he took. The bowels had acted twice; the motions were dark. The urine had been passed freely. He now began to assume a ghastly and cadaverous aspect; the hands and feet became cold; the pulse increased in rapidity. Stimulants and opium were freely given, but he continued to sink, and died on the 8th of December.

Post-mortem examination.—The body was emaciated. The thoracic organs were all natural; the left ventricle of the heart was closely contracted.

The bowels were universally glued together by soft lymph; in several places were collections of pus, which were circumscribed by the adhesions: the largest of these was in the left iliac fossa. When the adhesions were torn away small holes in the large bowel were broken open, through which fæcal matter exuded. During life these had been sealed up by the adhesions. The large intestine was diseased throughout. The mucous membrane on all the prominences, and in some places in the depressions also, was of a dark-brown colour, as if sloughing, and it could easily be peeled off from the tissue beneath. The parts thus altered were shaded off gradually from the unaffected portions. Under the microscope the superficial slough displayed a granular amorphous texture, in which one or two remnants of blood-vessels were seen. The slough was irregularly disposed, sometimes in wide patches, sometimes dotted here and there upon the natural membrane, sometimes occupying the transverse ridges. The small intestine was natural, excepting that there were a few patches of congestion, and that Peyer's glands were enlarged.

The older writers on medicine dwell upon enteritis as if it were a common disease; they give rules for distinguishing it from peritonitis, and make certain differences in treatment. But dead-house experience shows, that though enteritis is very common in connection with hernia and mechanical obstructions, and is a frequent result of the action of corrosive poisons, yet as a primary disease it is very rare indeed. In the course of four years, at St. George's Hospital, only four cases of this kind have been found in the *post-mortem* room.

In one case the last two feet of the ileum were affected much as in one of the cases just related. The mucous membrane was black and swollen; the other coats of the bowel were softened, and there were minute perforations, through which fæces had exuded. The subject in this case was a woman, 36 years of age, who, while under treatment for albuminuria, was seized with pain and tenderness in the belly, vomiting, diarrhœa, sweating, and prostration. She died on the fourth day.

In the fourth case the affection was limited to the duodenum, the walls of which were tumefied by the presence of a layer of pus between the mucous and muscular coats. The mucous membrane itself was not diseased, but all its folds were thickened by the infiltration in the submucous tissue. The pus was spread over the whole of the duodenum, but did not extend further in either direction. There was peritonitis, apparently consequent upon the inflammation of the bowel. The liver and kidneys were found in a state of "amyloid" disease. The patient in this instance had been attacked, four days before his admission, with rigors, colicky pains, looseness of the bowels, and urgent vomiting, all food having been returned almost immediately it was swallowed. When seen, the face was distressed, the tongue dry, the skin hot. There was general, but not excessive tenderness, and the parietes were tense. He had opium and stimulants; but died a week after the commencement of the illness.

These two cases, with the two already related, are all that have been found in the St. George's dead-house since my connection with it. In all the course of the disease was rapid. Death took place at periods varying between the fourth and ninth day of the disease. Vomiting was a constant symptom, while diarrhœa was noted in the course of three of the cases. In all there was great prostration. No cause was assigned in any instance, though it must be observed that in two of the cases the kidneys were diseased. The part affected was in two cases the

lower end of the ileum, in one the duodenum, and in one the large intestine. Dr. Dickinson, *17th of January*, 1865.

---

11. *Herniotomy for the second time—fatal. Thickening of the gut by the pressure of an ill-fitting truss on an irreducible hernia.*

Mr. Holmes exhibited a portion of small intestine which had been down for a considerable time in the sac of a hernia, and had been subjected to the action of an ill-fitting truss. The patient, a man of about 60 years of age, had been admitted a few days previously into St. George's Hospital, under Mr. Holmes's care, on account of strangulated femoral hernia. The same hernia had been operated on seven years previously, and the scar of the operation was perceptible. After this operation he was provided with a truss, which, however, became in time too weak to prevent the descent of the gut, and he still continued to wear the ill-fitting truss upon the unreduced bowel. It appeared, from his rather confused statement, that the hernia had been for a long time irreducible.

At the present operation, a coil of small intestine, about six inches in length, was found in the hernial sac, along with a small quantity of serum, mixed with flakes of lymph. Different parts of the herniated bowel presented striking differences in physical properties. Thus part of the intestine was greatly altered from its original structure, and felt thick and stiff, like stout leather, while the rest had the usual feeling and pliability of the natural intestine. This thickened portion constituted the greater part of the protrusion, and its bulk alone was a considerable obstacle to its replacement. The stricture, which was a tight one, was divided in two parts, with sufficient freedom to allow the finger to be passed into the peritoneal cavity around the whole circumference of the neck of the sac, and thus to establish the absence of all adhesion to the sac; but still great difficulty was experienced in replacing the thickened bowel, and it was not until the latter had been carefully emptied of its contents by methodical pressure, that this was effected, by previously pushing back the healthy intestine so as to draw on the remainder. The man went on moderately well for about thirty-six hours; but then symptoms of peritonitis became plainly marked, and he sank rapidly. After death a large quantity of pus was found in the peritoneal cavity. The omentum was adherent close to the femoral ring, and it was ascertained, by inquiry of Mr. Curtis,

of Staines, who had performed the previous operation, that the omentum had been left in the sac there, and had sloughed. The intestine which had been the seat of the morbid thickening was lying near the ring. It was about six inches from the ileo-cæcal valve, and about four inches in length. Its coats were thickened, so as to make the gut at least four times as thick as the neighbouring healthy intestine when the section was recent; but this difference diminished after exposure for some days. The mucous and serous coats appeared unaffected, the thickening involving the muscular tissue in part, but chiefly the areolar membrane on either side of it. The length of the mesentery in this case was not noted.

The preparation was brought forward as an additional warning (if any be required) against the use of ill-fitting trusses, and as an example of one of the causes (though perhaps a rare one) of the irreducibility of the hernia which may be produced by such instruments. Irreducibility of the hernia (when not the consequence merely of its size) is probably more frequently produced by morbid conditions of the omentum than of the intestine; but here the omentum was mechanically prevented from descending, by its firm union to the parietal peritoneum above the sac. When irreducibility is produced by a morbid condition of the intestine, this is most likely to be from adhesion—a condition which is itself likely enough to follow on the constant pressure of an ill-fitting truss; but here there was no adhesion whatever. The condition of the intestine described, must obviously have existed for some time. It was sufficiently strongly marked to excite immediate notice on the first handling of the gut; and it must evidently have opposed an insuperable obstacle to reduction by taxis through the undilated ring, since reduction was only effected with difficulty by direct manipulation through the ring after pretty free incision. It is also clear that the same condition of gut would greatly predispose to strangulation on the accidental entrance of a fresh piece of intestine into the sac, and would very probably render the patient more liable to peritonitis after strangulation and after operation. In this case, the presence of flakes of lymph in the fluid of the sac shows that the initial stage of peritonitis had set in before the operation.

Mr. Holmes, 21*st of February*, 1865.

12. *Large chronic ulcer of stomach. Perforation of splenic artery. Short duration of stomach symptoms.*

Mary H., æt. 76, a charwoman; admitted into University College Hospital, 5th of January, 1865. Had always been a very temperate woman. Subject to a winter cough for a number of years, but it left her three weeks ago, and then she began to suffer from "spasm" about her stomach; she had been sick ever since, bringing up all she took, but she had not brought up any blood. She had had great pain, lasting for an hour or two at a time, all over abdomen, but especially about the umbilicus, "shooting like needles run through to her back."

On the day of her admission, she first brought up blood, and was seen by Mr. R. D. Powell, the physician's assistant, about 9.30 A.M., when she was half vomiting and half coughing up a mixture of blood and mucus, in small quantities at a time. The blood was of a *bright* colour. I saw her about 4 P.M.: she was thin, but not emaciated; was pale, but had no yellowish or straw tint of the skin; the facies abdominalis not marked; no abdominal tumour was detectable. On closely questioning the patient, it was certain that the blood came up by vomiting, and that a little cough only occurred at the end of the vomiting. Chronic ulcer of the stomach was diagnosed. In the latter part of that afternoon, and up to the time of her death, which took place from exhaustion in the middle of the day on the 6th, she frequently brought up a large quantity of blood, the total amount of which, after the period of her admission, was estimated at about ninety ounces.

At the *post-mortem* examination, the blood was found to be in a very watery condition; the heart small and contracted, and the cavities very small; mitral orifice considerably smaller than natural. The stomach, pancreas, and spleen were all removed together. The stomach was unusually large, and the pancreas was firmly united to its smaller curvature. On being opened, the stomach was found to contain about eighteen ounces of blood, amongst which were many clots. At the part where the stomach was adherent to the pancreas there was a large ulcer, nearly circular; its longest diameter was two inches, and its smallest one inch and a-half; the edges were elevated and indurated, and the mucous membrane covering this elevated edge (or ridge-like circumference) was remarkably curved over towards the base of the ulcer. The base of the ulcer was nearly flat, and consisted of pancreatic tissue rendered more homogeneous and harder by exudation matter effused into it. At one part, not far from the centre of the

ulcer, there was an elevation of the base about the size of a hempseed, and of a somewhat redder or pinker colour than the rest; and when water was injected into the splenic artery, a rapid but small stream escaped from this little projection. There was no other ulcer.

This is a case, like many others already recorded, which shows of how short duration before death the positive symptoms of gastric ulcer may be, while the ulcer itself may have been long in progress. Doubtless the position of the disease had much to do with the long absence of symptoms sufficient to attract the patient's attention; for in many other instances in which the suffering has been slight, the position of the ulcer has been similar to what it was in this case. The opening on the surface of the ulcer, which was found to communicate freely with the splenic artery (I believe the opening was into one of the pancreatic branches of the splenic), left no doubt as to the source of the hæmorrhage.

Dr. Hare, *7th of March*, 1865.

---

13. *Colloid cyst in the wall of the cæcum.*

This specimen was obtained from the body of a woman, æt. 75, who died in the St. George's Hospital, under the care of Mr. H. Lee. It is not necessary to give particulars, as her death was quite unconnected with the cyst, which, indeed, had produced no symptoms.

At the *post-mortem* examination, a round hard mass was felt connected with the large bowel, which was found to be a cyst, distended with colloid matter, lying between the coats of the cæcum. It was about as large as an orange. It was situated opposite to the attachment of the appendix, which was thus closed at its mouth. The cyst contained a quantity of gelatinous matter such as belongs to colloid, which, under the microscope, showed numerous irregular bodies, about the size of pus globules, and much oil. A mass of solid tissue in the centre of the gelatinous mass consisted of an interlacement of fibrous tissue such as is usually found in colloid tumours. The cyst itself was very thin; it lay between the muscular and mucous coats of the bowel, from both of which it could be easily separated. There was nothing resembling cancer in any other part of the body.

The position of the cyst was such that it occasioned no obstruction; it lay close to the end of the cæcum out of the current of the fæces. The case is placed upon record as a pathological rarity rather from any practical interest which it has. Dr. Dickinson, *4th of April*, 1865.

---

14. *Case of meso-colic hernia.*

The subject of this peculiar arrangement died, from disease of the bladder and urethra, in the Liverpool Royal Infirmary, on the 25th of February, 1865. On raising the great omentum, a large cyst was brought into view, enclosing, with the exception of the duodenum, the whole of the small intestines.

This sac was formed of two distinct layers of peritoneum, an external

Woodcut 16.

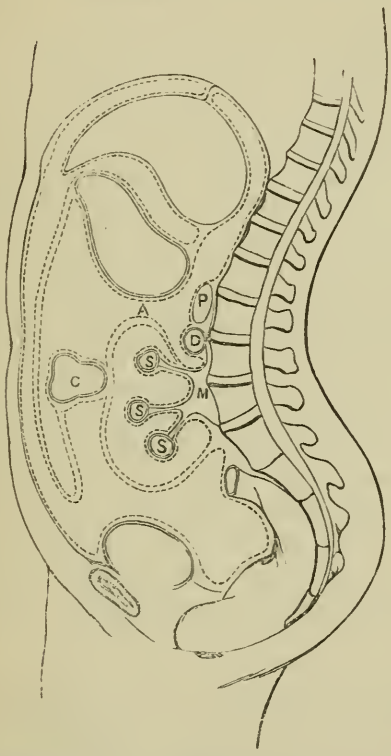


Diagram of longitudinal section. The *sac* represented of about one-third its proportionate size.

C Transverse colon.
M Mesentery.
S Small intestine.
A Process joining gastro-splenic omentum.
D Duodenum.
P Pancreas.

and internal, which were readily separated, and for three-fourths of its circumference it was in connection with the large intestine, being crossed above by the transverse colon, and on either side by the ascending and descending colon. The reflections of the parietal peritoneum were quite normal until it approached the spine, but here it was found to be continuous with the posterior wall of the sac. The position of the large intestine, in relation to the abnormal sac confining the small intestines, has already been alluded to; but it was found that the serous membrane covering the surface of the sac was continuous with the peritoneum investing the inferior aspect of the transverse colon, and that laterally the membrane covering the cæcum and ascending colon on the right side, and the descending on the left, was reflected over the front of the sac; inferiorly this layer, after covering the lower border of the sac, passed back to the spine, and from thence on to the pelvis. By separating the attachments of the ascending and descending colon from the sides of the sac, it was found that it was deprived of one layer of peritoneal covering. A large portion of the sac projected upwards beyond the transverse colon, though it was concealed until the omentum had been detached, from the greater curvature of the stomach, and this, like the portion already described, was formed of peritoneum. The peritoneum forming the sac appeared to be thus derived. (See Fig. 16.) The two ascending layers of the peritoneum, which assist to form the great omentum, having embraced the transverse colon, met; but instead of constituting the transverse meso-colon, and passing back to the spine in the usual way, they again diverged, the posterior layers descending, to be reflected over the inferior or larger portion of the sac, whilst the anterior ascended, to be reflected over the superior or lesser portion. The serous membrane covering the anterior aspect of the upper portion of the sac was prolonged upwards by a broad and strong duplicature to the gastro-splenic omentum, itself constituting an omentum; and tracing the peritoneum from this point downwards, it was reflected over the posterior aspect of the sac to the spine, where it became continuous with the serous membrane covering the mesentery and the abdominal parietes. On the right side, just below the cæcum, a ligamentous fold of peritoneum connected the sac with the brim of the pelvis.

The openings into the sac were three, all situated on the right side. The first and uppermost was for the admission of the duodenum, which entered immediately after having been crossed by the mesenteric vessels.

The aperture was formed by the folding together of the internal and external peritoneal coverings of the sac, its margin being firm and inelastic. The second opening was the largest, and through it the mesentery passed into the sac. It was placed obliquely from above downwards, in form being somewhat flattened or elongated, and it readily admitted the passage of the hand into the interior of the sac. The lateral borders of the mesentery were incorporated with the pillars of the orifice, and here also the mesenteric serous membrane was continuous with the external peritoneal covering of the sac; the anterior border of the aperture projected for nearly one inch and a-half into the sac, thus, as it were, roofing over the mesentery for a short distance after it had entered. The small intestine, which was within, was quite free, and normally covered with peritoneum, which appeared to be derived in the following manner: the peritoneum covering the mesentery was carried into the sac with it, and, having invested the small intestine, passed backwards to form the second layer of the mesentery, and then was reflected on to the interior of the cavity. The third and inferior opening was at the right border of the sac. Through it the ileum passed an inch before its termination in the cæcum. This aperture was very similar to the first one described. After the duodenum, mesentery, and ileum had been divided, the entire sac containing the small intestines was removed from the abdominal cavity; but it required to be carefully separated from the spine to avoid rupture, as the sac in this situation was thin, and would necessarily consist of only one layer of peritoneum.

Since writing the above description, I have ascertained that two cases of meso-colic hernia are recorded by Dr. Peacock in the second volume of the *Pathological Transactions* (p. 60).

Mr. E. R. Bickersteth, *4th of April*, 1865.

---

15. *Case of extensive invagination of intestine.*

This specimen was from an infant, æt. four months, who had suffered, for four days before he came under treatment, from well-marked symptoms of intestinal obstruction. Opiates were administered freely, and insufflation of the abdomen practised on two separate occasions without effect, and the child died on the eighth day from the first appearance of the symptoms. On *post-mortem* examination, the invagination was found to have commenced at the ileo-cæcal valve, from which the

extremity of the vermiform appendix projected in a congested and highly inflamed state. The whole of the large intestine, down to the commencement of the rectum, was blocked up by the included portion of the ileum, the extremity of which was found to be just above the sigmoid flexure. Dr. W. S. Playfair, 18*th of April*, 1865.

---

16. *Ulcer of the transverse colon, communicating with the stomach.*

E. H., æt. 45, a married woman, who had borne three children, of spare form, anæmic, but otherwise not unhealthy looking, was admitted into St. Thomas's Hospital on the 4th March, 1865. She stated that her illness began two months before her admission, with sickness and diarrhœa, which came on rather suddenly. The diarrhœa lasted about a fortnight. Subsequently the bowels had been constipated, often not acting for five or six days. She had not had any previous illness of importance, nor had she been subject to disturbance of the bowels, although she had not considered herself strong. At first she had had a good deal of pain in the abdomen, which she referred to the course of the colon, and chiefly to the left flank. There was a certain amount of uneasiness and tenderness in those parts, from time to time, during her stay in the Hospital. When admitted, the bowels had not acted for six days, and she had been more or less sick daily, for some weeks. The belly was quite flat and flaccid, tympanitic on percussion, and nowhere was there any local hardness or tenderness to be detected. Tongue clean, of a deep red, but moist; pulse 72, feeble; skin cool; thoracic organs apparently healthy. She complained of occasional pain in the belly, and of uneasiness in the stomach, especially after food, but there was no very great or distinct aggravation of pain by taking food. Her chief complaint and most prominent symptom was vomiting, and this was remarkable in its character. It occurred at various intervals, the stomach often remaining quiet for some considerable time after taking food. The vomited matter was of a pale fawn colour, very frothy, and closely resembling yeast, but of rather thicker consistence; of an intensely sour, disagreeable odour, but having not the slightest resemblance to fæcal matter. It retained its spumous character long after it was ejected, and in quantity was very considerable, amounting sometimes to several pints in the twenty-four hours. It was carefully examined by the microscope, but no sarcina was detected, nor any other special organic form.

The sickness was apparently controlled, in a measure, by creasote, but continued to recur at varying intervals up to within a few hours of her death. By enemata and a dose or two of blue-pill and rhubarb, the bowels acted, at first very scantily, but on several occasions more freely, the motions being for the most part of a healthy appearance and odour, and formed. On one, or at most two occasions, there was a little blood in the evacuations. The bowels however were often not moved for several days together, and between the 8th and 10th of March there was no vomiting for forty-eight hours. Food, even of the solid kind, was often retained for many hours, but the character of the vomit never changed. On one or two occasions there was a good deal of pain preceding a motion, but generally she was remarkably free from actual suffering. About the 21st œdema made its appearance in the feet and ankles, and on the 24th, the pulse became more frequent and feeble, and the vomiting took place seldom more than once daily. She died on the 1st April.

Post-mortem examination. — April 3rd, 1865. The body was emaciated, and the skin pale. The contents of the cranial and thoracic cavities were healthy, with the exception of a small quantity of tinted serum in the pleural cavities, with a few patches of soft lymph. The heart and large vessels were also healthy, with the exception of a large white patch over the right ventricle. The liver was in a state of fatty degeneration, and the gall-bladder was full of partly inspissated bile. The supra-renal bodies and pancreas were healthy. The stomach was large, and extended low down in the abdomen, its greater curvature being adherent to the transverse colon. On lifting up the latter, a ragged orifice was perceived on its under surface, from which a quantity of brownish fæculent fluid had escaped, apparently recently, into the abdominal cavity. The edges of this orifice were not in the slightest degree adherent to the small intestine, which lay behind it, nor was there any evidence of commencing peritonitis. On laying open the transverse colon, the ragged orifice above mentioned was found to be connected with a large irregular ulcer extending across the whole calibre of the intestine, with raised thickened edges and a sloughy base, in which there was a large oval aperture communicating with the stomach through the wall of the greater curvature. The colon above the ulcer contained several masses of solid fæcal matter. The intestine below was empty. The duodenum and upper part of the jejunum were somewhat distended, and contained

much brownish fluid like that which had escaped into the peritoneal cavity. Some similar fluid was also found in the stomach. There was no ulceration around the edges of the aperture in the stomach, but the base of the ulcer in the colon appeared to be extending through into the stomach in another spot. There was no other ulcer throughout the alimentary tract. A microscopical examination of the pulpy matter at the base of the ulcer showed the presence of columnar epithelium, granular and oily matter, but nothing indicating cancerous growth. The kidneys were small, weighing together six ounces. Their structure appeared healthy. The bladder was healthy.*

Dr. J. Risdon Bennett, 18*th of April*, 1865.

---

17. *Intestines of a patient who died of a relapse of enteric fever.*

William H., æt. 14, was admitted into the Fever Hospital, August 9th, 1864, having been ill a fortnight with fever and diarrhœa. The lenticular rose spots were well marked. On August 18th, or about the twenty-fourth day, he was convalescent, and at the end of another week he was up and going about.

August 29*th* (thirty-fifth day), he had an attack of rigors and pallor followed by pyrexia. Pulse 120; skin hot; no tenderness or fulness of abdomen; no diarrhœa; motion solid; no spots. On September 3rd he became suddenly much worse; the pulse rose to 140, and was very feeble; the features were pinched, and the abdomen was for the first time tumid and tender.

September 4*th* (forty-first day).—Died at five P.M.

Post-mortem examination.—There was quite a pint of dirty yellow fluid, with flakes of lymph and fæcal matter, in the peritoneum. All of the abdominal viscera, even the upper surface of the liver, were coated with soft yellow lymph. The intestines were intensely injected, and particularly so along the edges of their attached surfaces. The ileum was extensively ulcerated. The ulcers near the valve were in all stages of cicatrisation, some with the surrounding fringe of mucous membrane loose, others with it already adherent to the base of the ulcer. Proceeding upwards, the ulcers became less cicatrised, and at three feet

* Since the meeting at which this specimen was exhibited, some doubts have been expressed as to the spot where the ulcer originated. My own belief, founded on the clinical history, as well as on the *post-mortem* examination, is, that the ulcer began in the colon.—J. R. B.

above the valve the yellow sloughs were still adherent. Four feet above the valve were two large perforations, the lower one of an elliptical form, measuring one inch by one-third of an inch, situated at the lower end of a Peyer's patch, and its long diameter corresponding to the long axis of the gut, and the upper one having a diameter of one-fifth of an inch, situated at the upper part of the same Peyer's patch. Both perforations appeared to have been formed by the sloughing through of the entire coats of the gut. In addition to the ulcers now described, there was much recent deposit in several of Peyer's patches, and in many of the solitary glands for three yards above the ileo-colic valve, which had not yet ulcerated, and resembled that found after death from enteric fever about the fifth or sixth day of the disease. The spleen weighed ten ounces, and its texture was firm. The mesenteric glands were enlarged up to the size of walnuts.

Remarks.—True relapses occur in about six or eight per cent. of cases of enteric fever. These relapses are attended not only by a fresh eruption of rose spots on the skin, but by fresh deposit in the agminated and solitary glands of the ileum. No rose spots were observed during the relapse in the case now recorded, but death occurred as early as the sixth day of the relapse in consequence of perforation of one of the ulcers, resulting from the primary attack. Had the patient lived longer, fresh spots would no doubt have been observed. Two similar cases have already been recorded in the *Pathological Transactions*, by Dr. Peacock (vol. ix., 209), and by Dr. Hermann Weber (vol. xii., p. 96). Dr. Murchison, 18*th of April*, 1865.

---

18. *Case of sloughing of a piece of intestine.*

The preparation consists of a piece of small intestine about ten inches in extreme length. It was passed by stool. When it was first examined, one-third of its length was in the form of a tube, but it was laid open that the interior might be examined. The colour is dark brown; the breadth and thickness are pretty equal throughout. Muscular fibres are easily demonstrated under the microscope.

The patient, a very slender lad, æt. 13, was admitted January 29th, 1865, into the School Infirmary, Greenwich Hospital, under the care of Dr. Robert Grahame, R.N. He had been eating a large quantity of sweetmeats, and complained of pain in the epigastrium, with constipated

bowels. He was ordered an emetic, followed by a purge, with fomentations to the epigastrium. From these he received considerable relief.

On February 2nd he complained of nausea, with pain and tenderness in the right iliac region: he had bilious vomiting, thirst, loss of appetite, sleeplessness; the tongue was very foul and red at the tip; there was no eruption of any kind; the pulse was very small and frequent. He had an enema, and was ordered ice and effervescing draughts. The bowels were freely moved by the enema: next day he had pain and tympanitic swelling of the abdomen. He continued to present much the same symptoms, viz., foul tongue, thirst, loss of appetite, pain and tenderness in right iliac region, occasional bilious vomiting and diarrhœa, without any eruption, till February 12th, when there was found in his stool the piece of intestine which has already been described.

After this was passed he appeared to be somewhat relieved. At first, however, he suffered from exceedingly painful diarrhœa, accompanied by discharge of flatus, the bowels being moved six or seven times a day. This symptom was very much relieved by the compound ipecacuan powder, in doses of three grains. He was ordered six ounces of port-wine daily, and his diet consisted of milk and beef-tea. Under this treatment he recovered steadily though slowly, and in about six weeks he was perfectly convalescent.

In this case there must evidently have been intus-susception of a piece of the small intestine, which was afterwards separated as a slough. It is remarkable that the signs of ileus were never present: the bowels could always be moved by means of enemata; the patient had bilious, but not stercoraceous, vomiting.

Dr. Dickinson *for* Dr. MacLaurin, R.N., 2*nd of May*, 1865.

---

19. *Cancerous stricture of the rectum, from a patient in whom an anus was established in the left loin for the relief of symptoms.*

A man, æt. 29, was admitted into the London Hospital in July, 1864, suffering severely from cancer in the rectum. He had lost all power of retaining his fæces, and was subject to a constant flow of fæculent matter, with blood and mucus. On July 19th, the colon was opened in the left loin by operation, linseed tea having been previously injected into the bowel. He recovered favourably from the operation,

and returned to his home in Yorkshire, where for a time he was in a state of comparative comfort. He had a good appetite, slept well, and gained a stone in weight. Six months after the operation, his health began to decline from the progress of the disease. He had frequent hæmorrhage from the bladder as well as from the rectum, lost flesh and strength, and died exhausted, April 29th, nine months after the operation.

The body was examined by Dr. Guy, of Doncaster, eighteen hours after death. It was anæmic, and much emaciated. The descending colon was firmly adherent at the seat of the artificial anus, and all around was quite healthy. The bladder was contracted, and contained a small quantity of urine. The interior was rugous, the muscular fibres being well developed. Its posterior wall was thickened, extremely hard, and firmly united to the cancerous rectum. Two inches above the anus there was a contraction in the rectum from carcinomatous infiltration of the tissues. Above the stricture there were small ulcers in the mucous membrane. The other abdominal viscera were healthy but anæmic. Mr. T. B. Curling, *16th of May*, 1865.

B. LIVER, ETC.

20. *Amyloid disease of liver.*

This specimen is a liver in an advanced stage of amyloid degeneration, and is remarkable for its irregular nodulated form.

The two lateral lobes are prolonged upwards, as it were, leaving a deep depression between them; the anterior border is much thickened, and projects considerably beyond the notches for the gall-bladder and round ligament, and in the centre of the upper surface is a smooth globular enlargement three inches in diameter. The liver has all the characters of the so-called amyloid or albuminous degeneration, and gives a most characteristic reaction with iodine. The spleen and kidneys had undergone a similar change.

The patient was a man, æt. 33, who died in the Middlesex Hospital, on October 12th, under the care of Dr. Greenhow. He had enjoyed good health up to the commencement of the hepatic enlargement, and no cause could be assigned for the disease. The uneven character of the enlargement gave rise to some difficulty in forming

the diagnosis. The smooth globular prominence on the upper surface had much the characters of an hydatid tumour, and subsequently the nodulated border might easily have been mistaken for cancer. There was latterly great ascites, and during the last month the patient, who had previously been in good condition, emaciated rapidly. The liver weighed eleven pounds eight ounces and a-half.

Dr. CAYLEY, 18*th of October*, 1864.

---

21. *Series of gall-stones.*

This series of gall-stones consisted of the calculi, either passed during life or removed from the body after death, of seven different individuals, and Dr. Harley's object in showing them was to illustrate the following points:—

1*st*. That the dangers arising from hepatic calculi are not in proportion to the size of the stone.

2*nd*. That a small stone may lead to fatal peritonitis, and a large one give rise to no symptoms—not even discomfort during life,—its existence only being detected after death.

3*rd*. The pain caused by the passage of the stone appears to depend more on its shape than its absolute size, a small angular one causing much more discomfort than a large oval one.

4*th*. The danger arising from biliary calculi does not cease after the calculus has found its way into the intestinal canal. At least two cases of death are reported as having occurred from impaction of the gall-stone in the small intestines.

5*th*. A gall-stone passed along with the fæces ought to be looked for at the bottom, not at the surface of the fluid.

6*th*. All the symptoms of the passage of a gall-stone may exist and none be found in the excretions, in consequence of their arising from the passage of inspissated bile.

Dr. GEORGE HARLEY, 18*th of October*, 1864.

---

22. *Hydatid tumour of the liver threatening to burst. Paracentesis. Recovery.*

On August 3rd, 1864, Hannah S., a very nervous woman, æt. 31, consulted me about a tumour in the region of the liver. She was a cook in a medical man's family. In the summer of 1863 she had been

laid up for three weeks with a pain across the stomach, but, with this exception, she had never suffered from any symptom of abdominal disease until about nine weeks before she came to me. She was then seized suddenly with acute pain in the region of the liver, which lasted for about two hours. For several days she vomited everything she ate, and she had great pain in her side when she attempted to cough or turn in bed. She kept her bed for a week, and did not resume her work until after three weeks. The liver was then for the first time observed to be enlarged and prominent, but the patient was unable to say whether this enlargement had existed before the attack of pain or not. On examination, there was found to be a slight bulging in the right hypochondrium below the ribs, this bulging being apparently continuous above with the liver, extending to half an inch below the umbilicus, and transversely from an inch to the left of the mesial line to about three inches and a-half to the right of it. The vertical hepatic dulness corresponding to the right nipple was seven inches, four inches and a-quarter of the dull space being below the edge of the ribs. The tumour was tense, but elastic and almost fluctuating. It was slightly tender on firm pressure. It did not seem to be adherent to the abdominal wall. Posteriorly the hepatic dulness did not extend higher than usual, and its upper margin was horizontal. The respiratory sounds at the right base were normal. The patient was slightly sallow, but had no decided jaundice. The tongue was clean, the appetite good, and the bowels regular. There was no ascites and no anasarca. The urine contained neither albumen nor bile-pigment. Pulse 84.

On August 7th, the patient had a return of pain in the tumour, accompanied by vomiting and purging, lasting for two or three days. For several days after this attack the tumour was tender, and over its surface coarse friction could be both heard and felt during the respiratory movements.

On August 19th, Hannah S. was admitted under my care into Middlesex Hospital, and placed on iodide of potassium, five grains three times a day.

On August 24th the tumour was noted as more tense and tender. On the night of September 2nd, the patient had an attack of acute pain in the right side, greatly increased by pressure, movement, or a long inspiration, and accompanied by much nausea, but by no vomiting or rigors. Pulse 96. Under the use of opium, poultices, and rest, these symptoms gradually subsided, but the tumour continued tender, the

friction was again distinguishable for several days, and the pulse did not fall below 96. On September 9th, the patient had another similar attack of pain, but more severe; the pulse rose to 116, and the friction returned. On September 14th the pain was less, but the tumour was observed to extend more to the right side, and was less rounded. On September 17th there was another severe attack of pain, and indeed since August 24th the tumour had never been free from tenderness, while the patient felt herself gradually getting weaker, the pulse being rarely below 108.

Although there was no evidence of firm adhesions over the tumour it was now determined to puncture it. From the first the tumour had been diagnosed as an hydatid, and, indeed, the object of the patient's admission into Hospital was to have it punctured. All who examined were agreed that it contained fluid, and the only other affections at all likely to produce the appearances observed were a distended gall-bladder and an abscess of the liver. The tumour did not occupy quite the situation, and latterly did not present the shape, of a distended gall-bladder, and there had never been jaundice. The persistent pain and tenderness noted for several weeks pointed rather to abscess, but there had been no rigors or perspirations, and moreover the tumour had not increased much in size since it was first observed. Supposing the tumour to be hydatid, there was reason to fear that it was about to burst, an event which would in all probability have been followed by a fatal result.

On September 20th my colleague, Mr. Hulke, tapped the tumour with a fine trocar—the canula of which was scarcely so large as a No. 1 catheter,—and drew off about twelve fluid ounces of clear limpid liquid, the specific gravity of which was 1009. No echinococci or hooklets could be discovered in it, but it was found to contain a large amount of chloride of sodium and no albumen. Neither did it contain a trace of a salt of iodine, although iodide of potassium had been taken almost continuously for several weeks. This fluid was exhibited to the Society.

On removing the canula, the abdominal parietes were pressed down against the tumour, and the puncture was covered with collodion. The patient was kept on her back for forty-eight hours, and not permitted to move on any consideration. Twenty drops of laudanum were administered immediately after the operation, and for two days an opiate was given about once in four or six hours.

The night after the operation the patient slept well. On the follow-

ing day the urine was retained and was drawn off by catheter, and on September 22nd the abdomen was greatly distended and tympanitic, the skin hot and dry (temperature 101°), the pulse 120, and there was much thirst. Still there was less pain and tenderness over the tumour than before the operation. The bowels had not been open for two days. An enema of turpentine and confection of rue brought away a large quantity of flatus, and the patient at once began to improve. On September 26th, the pulse was 96, the tongue clean and moist, and the appetite was returning. For the first time for several weeks the patient could tolerate free manipulation of the tumour, the dimensions of which were much reduced. On September 27th, pulse 84; the collodion was removed from the wound, which was perfectly closed. On September 30th, the patient was able to get up.

Convalescence was retarded by an attack of facial rheumatism, and by other trifling ailments; but on November 22nd, the patient was able to leave the Hospital. The dimensions of the tumour were gradually diminishing, so that the dulness from the upper margin of the liver to the lower end of the tumour did not exceed five inches and three-quarters. The tumour also was quite soft and free from tension, and could be manipulated without causing any pain. The tongue was clean and moist, and the appetite and digestion good. Pulse 100.

[June 3rd, 1865.—The patient has now almost regained her ordinary health. For the last four or five months she has been in service as a cook, and she can walk several miles without feeling fatigued. There is still a fulness in the region of the tumour, but the lower margin of the liver is quite an inch above the umbilicus. The patient is also sensible, from her clothes, of a great diminution in the girth of the lower part of chest, and she is also able to wear stays, which she had not been able to do for nearly twelve months.]

Remarks.—This case was a good illustration of the advantages to be derived from paracentesis of an hydatid cyst of the liver. There was every reason to fear that the case might terminate fatally by the bursting of the cyst into the peritoneum, or in some other direction. No medicine with which we are acquainted seems to have any power in destroying an hydatid. It is believed by some that iodide of potassium possesses this power, but the absence of iodine from the fluid drawn off in this case makes it doubtful if the salt ever reaches the hydatid. Chloride of sodium, another vaunted remedy, can hardly be supposed

to be injurious, as so much of it exists in the fluid which appears to be necessary for the existence of the hydatid. Paracentesis really holds out the only chance of averting dangers which, sooner or later, are tolerably certain to result from these tumours, in cases where they are large enough to enable us to diagnose their presence. In the case now recorded the tumour had probably existed for a long time, and only attracted notice when it began to make its way outwards and excite peritoneal inflammation.

Dr. Murchison, 1*st of November*, 1864.

---

23. *Case of meningitis with atrophy of the liver, supervening on jaundice.*

A drummer, æt. 20, a well developed muscular young man, who had been several times previously under treatment for syphilis, was admitted into the Hospital of the Scots Fusilier Guards, on the morning of October the 16th, with a small soft chancre on the prepuce. He at the same time was suffering from an apparently slight attack of jaundice. His general health was seemingly unaffected, and the last named affection was not even alluded to by the patient when desired to state the nature of his ailment prior to admission. Ordered aperient (mercurial) pills, followed by senna draught. On the morning of the 18th, the Hospital-sergeant, on casually entering the ward at 8 o'clock P.M., found the man in a state of complete insensibility. His attention was drawn to the drummer's condition by observing a pool of water trickling on the floor from beneath the bed. The patient's urine was involuntarily emitted. The men in the adjacent beds were not aware of their comrade's condition, and said that they had noticed him to rise out of bed, go to the water-closet and return, during the night, without making any remark or complaint of indisposition. When visited soon after the sergeant's report, the man was found comatose: eyes not injected, but pupils dilated and quite insensible to light; body quite cold; pulse weak and slow; respiration not laboured. No evidence of any previous vomiting. Subsequently, after reaction, when warmth had been restored, he showed some slight evidence of understanding questions put in a loud voice, but could not articulate in the least degree. Later in the day, much restlessness, jactitation of the limbs, and turning from side to side were observed. The pulse increased in strength, but was frequent and compressible. The bowels did not act, but the urine was voided copiously, and it tinged

the linen a moderately yellow colour. The above symptoms continued almost unchanged until death took place at a quarter to four o'clock P.M. On the 19th, the coma had become more profound and the breathing somewhat heavy, but decided stertor was not present. The skin, previously moist and warm, became rather dry and hot on the day of his decease. A few hours before death the eyes were noticed to be a little suffused, and there was slight contractile power in the pupils. Much restlessness existed at this time. The bowels acted shortly before he died, and the motions were only slightly darker than ordinary. The treatment consisted of sinapisms to the legs, hot bottles to the feet, blisters to the head and neck, and full doses of calomel and croton oil, followed by stimulant enemata. But little information could be gained as to the man's history immediately prior to admission. It would seem that he had been drinking heavily for some days antecedent, and had also complained of stoppage of urine for a long period before that. When under treatment for syphilis on previous occasions, iodide of potassium had been prescribed, but not mercury. The records of his case stated that the sores then were not specific, and the iodide was probably given in consequence of some eruption of doubtful character which did not prove to be of a specific nature.

Post-mortem examination.—Head.—Brain congested throughout its structure. In the right hemisphere the cavity of the lateral ventricle was closed up by firm adhesion of the choroid plexus to its sides. These vessels showed evidence of inflammatory action. There was sub-arachnoid effusion and opacity, pretty general; adhesions between dura mater and skull-cap and brain, apparently of old standing.

Chest.—Viscera healthy.

Liver.—Weight, two pounds and eight ounces; small, and firm in structure. When cut into, it was of a deep yellow colour, with numerous dark purple patches interspersed throughout. Gall-bladder shrunk, its coats much thickened and inflamed; it contained a little bile—half an egg-spoonful—of the consistence of tar and very dark.

Spleen.—Somewhat congested; weight, eight ounces and four drachms.

Kidneys.—Both extremely congested, and somewhat enlarged. The pelves contained thick turbid urinary secretion of a yellow colour.

Dr. F. ROBINSON, *15th of November*, 1864.

Report on the above specimen.—After having examined, microscopically and otherwise, the liver and kidneys of the above mentioned case, your reporters have arrived at the conclusion that it is one of acute or yellow atrophy of the liver. The reasons which have chiefly induced them to adopt this opinion are the following:—

1st. The liver is very much under the normal weight, being only two pounds and a-half; whereas the normal liver of a man of the size and development described in the author's paper, ought to weigh about four pounds, namely, 1-36th of that of the body.

2nd. When the liver is examined microscopically, scarcely any hepatic cells are to be found; and the few which do exist are very granular, and much stained with bile-pigment. The field of the microscope, however, is chiefly occupied with free granular matter and oil globules, apparently the escaped contents of disorganized cells. It is necessary to remark, that as the specimen is somewhat old, the almost universal destruction of the hepatic cells may be in part due to commencing decomposition.

3rd. The tissue of both kidneys, when examined microscopically, is seen to contain numerous crystals of tyrosine. The crystals are mostly in the form of spiculated balls, and stellate groups of fine needle-shaped prisms. As many as five sets can occasionally be counted in the field of the microscope. Their distribution is however by no means uniform.

4th, and lastly. The history of the case, the size of the liver, and the presence of tyrosine in the kidneys completely accord with the view of its being one of acute yellow atrophy.

Dr. G. Harley,
Dr. Murchison, 6*th of December*, 1864.

---

24. *Hydatid tumour of the liver opening into the lung.*

J. W. æt., 19, admitted 1st June, died 14th November, 1864, under Dr. Beale. Single. Good health up to two years ago. Four years ago, pain in right hypochondrium, after bruise over liver. For last two years has suffered from cough and expectoration. Four months ago he was admitted into St. Bartholomew's Hospital, for acute pain in right hypochondrium, and jaundice. The jaundice quickly disappeared. A month ago he again had pain in right side, and noticed slight enlargement there. Pain was worse on coughing.

On the 29th May, the cough suddenly became very urgent, and for several hours was incessant, and the expectoration copious. The cough has much abated during the last two days.

On admission into King's College Hospital: anæmic, distressed, ill-nourished. Constant dull pain in right side, but worse on deep inspiration. Great tenderness on same side. Some dulness at lower part of right side. Respiratory sounds inaudible behind. Breathing harsh above. A to-and-fro rubbing sound an inch below and a little to the right of right nipple. Respiration louder on left side. Rhonchus and sibilus on both sides. Heart natural.

Abdomen was enlarged on the right side one inch more than on left. Complete dulness over right hypochondriac, lumbar, and epigastric regions; also over upper third of umbilical, and half the left hypochondrium nearest the median line. The free margin of the liver could not be distinctly felt. Urine healthy; bowels open. Expectoration copious, and muco-purulent.

June 4*th.*—Cannot lie on either side without coughing violently; the sputum then escapes almost in a stream through mouth and nostrils; sputum more yellow.

June 14*th.*—Bulging of right side very perceptible.

June 19*th.*—Expectoration, about four pints of brownish green fetid purulent matter in half an hour. No pain or unusual symptom preceded, but increased dyspnœa followed. No lung tissue seen under the miscroscope.

June 21*st.*—Very large crepitation, almost gurgling, at base of right lung.

July 3*rd.*—Spat up one pint and a half of sputum in two hours and a half, some of which had an acid taste, burning his throat.

Bulging of right side disappeared.

* * * * * *

July 21*st.*—Coughed up a pint of matter like yolk of egg, which with nitric acid gave a not very decided play of colours.

Under microscope.—Mucous cells, oil globules, with crystals of biliary matter within them.

Bowels open. Motions invariably pale.

August 3*rd.*—Much better. Hardly expectorates half a pint in twenty-four hours.

August 29*th.*—Discharged convalescent.

* * * * * *

October 17*th.*—Re-admitted, with a return of all the symptoms. Dulness on right side. Chest symmetrical. Half a pint of muco-purulent matter expectorated in twenty-four hours.

* * * * * *

November 13*th.*—Shivering and severe pain in lower part of abdomen, which gradually extended up to the umbilicus. Nausea and dyspnœa. Pulse 150. Evidently in a state of collapse. Died 14th November, at six o'clock in the evening.

Post-mortem examination, sixty-four hours after death.— Upon opening the abdomen, it was found to contain a good deal of pus, and the intestines were matted together by lymph. The liver was very large, and extended to a point midway between the umbilicus and the pubes. The front part of the right lobe was coated with lymph, and somewhat adherent to the anterior wall of the abdomen.

On opening the chest, the bottom of the right lung and the upper part of the right lobe of the liver were found to be intimately adherent.

The bronchial glands at the root of the lung were of a very dark colour, and contained some cheesy tubercle.

The heart, lungs, and liver were removed altogether, and it was then discovered that there was an opening, which had been closed by adhesion to the wall of the chest. This opening was about the middle of the anterior border of the lower lobe of the right lung, and when found was large enough to admit the fore-finger very readily. During the use of force necessary to remove the viscera, yellowish transparent flakes, the colour of yolk of egg, and of gelatinous consistence, exuded from the opening described above. These were evidently the remains of hydatid cysts.

Upon cutting open the trachea and bronchial tubes, and tracing them in the direction of the opening, they were found to lead to a large cavity of irregular shape, about the capacity of a very large orange. This contained the remains of hydatid cysts, similar to those which had exuded from the opening on removing the viscera. The cavity extended, as it were by horns, upwards and outwards into the substance of the lung, and downwards through an aperture in the diaphragm into the liver for about one inch and a-half.

At the termination of the horn passing into the liver, there was much thickening and puckering of that organ; the liver, lung, and diaphragm being closely adherent around the canal.

Between the gall-bladder and the liver was an abscess, about the

size of a small orange; and close to this a portion of the liver, about as big as a walnut, was dark coloured and broken down, and apparently about to suppurate.

The gall-bladder was much shrunken and contracted on several gall-stones.

There were one or two rounded prominences on the surface of the liver, looking as if they might be abscesses or hydatids, but nothing of the kind was found on section.

The spleen was normal.

Kidneys pale—probably fatty.

The liver tissue was somewhat fatty.

Remarks.—He was probably getting well from the original hydatid, when the abscess burst into the peritoneum and killed him. The abscess may have been due to constriction of the nutrient vessels in the puckering of the original hydatid. No ecchinococci claws were found at any time. Dr. Julius Pollock, *3rd of January*, 1865.

---

25. *Enormous accumulation of hydatids in the liver, producing great abdominal distension.*

W. D., æt. 16, was admitted into the West London Hospital on the 25th of January, 1864. His appearance was indicative of a weak and unsound constitution. He was pale and rather emaciated, with a heavy expression of countenance, and rather small for his age. His mother stated, that about eighteen months previously he had received a blow over the region of the stomach, which made him feel very unwell at the time, and caused him much pain. On the following day, while speaking of the blow he had received, and putting up his arms to show the position he was in at the moment, another boy who was present, and wishing to illustrate the fact more forcibly, struck him a sharp blow on the same spot; this caused him great additional pain, and his mother observed, that he never appeared to recover perfectly, but was generally ailing or complaining of feeling unwell. About two months previous to applying to the Hospital, he had complained of a fulness about the right side, and over the stomach.

A hard irregular mass could be felt, extending from the margin of the liver across the stomach; no defined boundaries could be discovered,

but the scrobiculus cordis was tense and protruding, causing the patient to bend rather backwards. Percussion gave a dull sound all over the mass; it was not painful to the touch, or even to considerable pressure.

Taking the unhealthy appearance of the boy with the other appearances already mentioned, the case gave the idea that malignant disease was present, and consequently the prognosis was very unfavourable; this seemed to give dissatisfaction to the mother, who could not be convinced that the boy's life was in danger. He was, however, put under treatment, but as was anticipated, he got worse, and the swelling increased. At the end of about two months his mother took him away, and obtained admission for him into another Hospital (St. George's), where he remained about four months. He steadily got worse, however, and on leaving the Hospital, he was kept at home for some time.

On the 25th of November, 1864, he again came under Dr. Logan's care, at the West London Hospital. His abdomen had now become enormously enlarged, and had a nodulated feel when examined by the fingers, and in one or two places, particularly about the navel, the nodulated character became visible to the eye. The legs and arms were very much emaciated, but the ankles were swelled; an obscure sense of fluctuation could be discovered at the lower part of the abdomen. He continued to get gradually worse, and died on the 11th of February, 1865.

The mother was questioned as to his previous mode of living, and whether he had ever been in the habit of eating raw or under-cooked meat. She stated that he had had a liking formerly for under-done meat, but that she was not aware that he had ever suffered from tape-worm; he had, however, been subject occasionally to pass small worms, but not to the extent to cause any inconvenience. She attributed the illness to the blows he had received eighteen months previously.

It may be a point of interest to consider the probable effect of the blows, and whether they may, or may not, have contributed to the development of the hydatids by the congestion of the liver which would probably follow, and the greater probability that the ova might be more readily arrested in the liver under such circumstances.

Post-mortem examination, sixty-four hours after death.—The body was small and exceedingly emaciated; the belly was prominent and bulged forward, its anterior surface having numerous round projections like a thin bag filled with apples; numerous veins coursed in various directions. The lower part of the tumour projected a few inches beyond the pubes.

The general circumference of the tumour in front was forty-five inches and a-half; from hip to hip it measured thirty-three and a-half inches; round the body, forty-five; and from the ensiform cartilage to the pubes, twenty-one inches.

The integuments were very thin over the tumour, and so firmly adherent were they to the mass, that it was almost impossible to dissect them off. The tumour was found to be an enormous agglomeration of hydatids springing from the anterior portion of the left lobe of the liver, which in the process of development and extension had invaded every part of the abdominal cavity, becoming incorporated with neighbouring structures, and especially with the entire peritoneal surface, penetrating it in front, at the sides, and upwards, the hydatids being attached to the muscular structure of the diaphragm and the abdominal muscles. The intestines and stomach were pressed backwards, but the hydatids were in contact with the kidneys and spleen, compressing them into a small bulk; both of the former had their pelves dilated; the urinary bladder was firmly compressed and could contain no urine, as the pelvis was almost filled with masses of the parasites. It was ultimately found that the liver was the organ in which they originated, for the anterior part of the left lobe was involved, whilst the remainder was free, but so firmly compressed as to cut with an almost cartilaginous hardness. There were probably some thousands of these animals, which, when their extension and growth had been arrested by the limits of the abdominal cavity, destroyed life by arresting its most ordinary functions. No other organ than the liver was found to be diseased, but the heart and lungs were much pushed upwards. The legs were œdematous.

Dr. Gibb *for* Dr. Logan, 21*st of February*, 1865.

---

26. *Large gall-stone passed per anum.*

Dr. Leared exhibited for Mr. Holmested, of Braintree, a gall-stone, the shape of an olive, one inch and a-quarter long and one inch in diameter. Its surface was covered with smooth tubercles, and it was found on section to consist mainly of cholesterine. It was passed per anum, after about thirty hours of pain and vomiting, by a woman, who had never previously suffered from symptoms of gall-stones.

Dr. Leared, 7*th of March*, 1865.

---

27. *Case of gall-stones.*

The interest of this specimen depended on the history of the case, as showing what prolonged suffering may be caused by gall-stones, and how difficult their diagnosis sometimes proves.

In August, 1863, a married lady, æt. 48, came to London to place herself under my care. She had suffered for twelve years previously from sudden attacks of excruciating pain, beginning in the epigastrium and extending over the abdomen. The pain lasted usually for four or five hours; it was succeeded by retching and extreme prostration. Two of these attacks happened, within three days of each other, whilst she was in London. There was slight tenderness in the region of the gall-bladder, and on one occasion she had been jaundiced for a week. The attacks, however, seemed to be almost always excited by some accidental cause. The first seemed due to a shock, on hearing at the same time of the death of two friends; afterwards mental disturbance, fatigue, or indigestion, were usually set down as the source. There was well-marked spinal tenderness. I nevertheless suggested to the late Mr. Harrison, of Braintree, her medical attendant, that the attacks depended on gall-stones, she subsequently passed under the care of Mr. Holmested, of the same place, and, after a severe attack in October last, the gall-stone exhibited was discovered; it is smooth, of the size of the kernel of a filbert, and facetted, showing that it had been in contact in the gall-bladder with others. Since the passage of this stone, the patient has experienced some of the old attacks, but they have been much less frequent. Dr. Leared, *7th of March*, 1865.

---

28. *Case of hydatid tumour of the liver bursting into the bile-duct.*

On the 29th of October, 1861, I was consulted by Mr. ——, a solicitor, æt. 53. For some weeks he had been suffering from flatulence, and a feeling of tightness and oppression after meals, and three days before he had been attacked with severe pains in the abdomen resembling colic. The countenance was somewhat sallow; the motions were pale, but contained bile; there was no bile in the urine, which was scanty and dark, having a specific gravity of 1027, and depositing much lithic acid. The vertical hepatic dulness in the right mammary line extended about an inch below the edge of the ribs, and all along the right

hypochondrium there was slight tenderness on pressure. Pulse 64. His digestion had always been good, except once, about seven years before, when he had several attacks of pain like colic in the abdomen, similar to those from which he had recently suffered. The medicines prescribed by myself, and afterwards by Dr. Watson, who met me in consultation, failed to give any relief.

On November 24th, the patient had an attack of vomiting, followed by an aggravation of the dyspeptic symptoms, and by increased tenderness in the right hypochondrium.

On December 6th, he was much worse. The tenderness in the right side had increased greatly, and there was also constant pain there, which became very acute when he took a long breath or coughed. The tongue was furred and moist. The bowels were very costive, and there was considerable tympanitic distension of the abdomen and increased sallowness, but no vomiting. The pulse had risen to 88, and the respirations were 30, and thoracic. Fifteen leeches were applied to the seat of pain, twelve more on December 8th, and eight more on December 10th, with poultices in the intervals; the bowels were kept open by castor oil and turpentine enemata.

On December 12th, the pain was much less, but there was still considerable tenderness, and a stitch in the right side on taking a breath or coughing. The countenance was very sallow, but there was no decided yellowness of the conjunctivæ, and the motions, though pale, contained bile. The vertical hepatic dulness in the right mammary line was five inches. Nothing like a defined tumour could be felt, and there was no bulging of the ribs. The breathing at the base of the right lung was normal. Pulse 88.*

On December 16th and 17th, the patient passed for the first time a number of hydatid cysts in a bilious motion.

On December 18th, he was much worse; there was decided jaundice of the integuments; the urine was loaded with bile-pigment, and there was not a trace of bile or of hydatid membranes in the motions. There was constant pain in the right side, in addition to occasional paroxysms like colic; lips parched; tongue furred; much perspiration in the night and great prostration; pulse 100. The treatment consisted in the constant application of poultices to the side, and in the administration of quinine and of blue-pill and opium.

* From this date until Jan. 25th, I attended Mr. ——, in conjunction with Dr. F. Davies, of Upper Gower Street.

December 19*th.*—Is much easier. Has passed innumerable hydatid vesicles, from a pin's head to an orange in size, per anum. Skin and urine still jaundiced and no bile in stools.

December 20*th.*—Fæces to-day are tinged with bile, and still contain numerous hydatid cysts.

December 21*st.*—Jaundice almost gone; motions still contain hydatids and abundance of bile. Below and to the left of the right nipple, there is tympanitic percussion over a space the size of a crown-piece. Both above and below this there is hepatic dulness. Pulse 88; pain much less; tongue cleaning.

The patient continued to pass a few hydatid vesicles with each motion up to December 31st, and the tympanitic percussion sound was noted a few days later than this. He had occasional sharp but temporary attacks of pain in the abdomen, resembling colic. On January 6th, 1862, he was quite convalescent. Pulse 72. The tympanitic sound noted above could no longer be distinguished, and the upper border of hepatic dulness was one inch lower than before. At the end of January Mr. W. was able to drive out, and on February 19th he went to Ventnor for change of air, returning to London on March 11th.

Once while at Ventnor he had a severe attack of colicky pain lasting for an hour and a-half, and "bending him up double." He had a similar attack, but less severe, a few days after his return to London. Both attacks were unaccompanied by vomiting. Every day he gained strength, and on his return to town he was able to resume his business. On the 2nd of April he went down to Essex on business. He walked about the country several miles every day, feeling none the worse, and returned to town on April 6th.

On April 8th he went to his business as usual and walked several miles. Shortly after dinner, about 7 p.m., he was suddenly seized with severe pain in the abdomen, which returned in paroxsyms and this time was accompanied by vomiting. There was slight tenderness of the epigastrium, but no jaundice. The pulse was only 84. Repeated doses of opium and chloric ether were prescribed, and poultices were kept constantly applied over the abdomen.

On the following day the paroxsyms of pain had ceased, but there was more tenderness at the epigastrium and in the right hypochondrium, and considerable pain when he coughed or moved. The vomiting had not quite ceased. There was slight sallowness, but the stools

contained bile: pulse 86. Ten leeches were ordered to be applied to the side, and the poultices and opiates were to be continued.

The patient did not apply the leeches, as he felt better. In the afternoon he had two severe attacks of rigors, after which he felt so much better and free from pain that he thought it unnecessary to send for me.

On the morning of April 10th he said that he felt so much better that he had eaten a good breakfast and wished to get up and go down-stairs; but he was in a state of extreme prostration, and evidently sinking. The pulse was 120 at the elbows and imperceptible at the wrists. The sickness had ceased, but the features were pinched, and the skin was cold and covered with clammy sweat. He gradually sank, and died at 8 P.M.

Post-mortem examination.—The abdomen only was examined. On opening this cavity the intestines appeared healthy, but distended with gas. There was no exudation or increased vascularity in the general cavity of the peritoneum. The large intestines contained a quantity of pulpy material of the colour of cream, and without any tinge of bile. The duodenum and jejunum contained bile.

The left lobe of the liver was healthy and non-adherent. Both the upper and the under surfaces of the right lobe were connected to the adjoining parts by firm adhesions; near the right edge of the liver a few of the bands of adhesion fastening it to the ribs were ruptured, and at this point there was a patch of recent lymph not larger than a square inch, with slightly increased vascularity round about. In the substance of the right lobe was an irregularly shaped collapsed cavity, the size of a large orange. The walls of this cavity were partly formed by the ribs and the surrounding adhesions. The inner surface of the cavity consisted of indurated hepatic tissue, presenting a shreddy appearance, and was not lined by any hydatid membrane. The cavity was almost empty, but it contained four or five collapsed hydatid vesicles about the size of a shilling. Communicating with it was a greatly dilated bile-duct, passing directly on to the common duct. The entire duct from the cavity to the orifice in the duodenum was large enough to admit the tip of the little finger. Further back in the right lobe, and quite distinct from the cavity now described, was another about the size of a plum, which was lined by an obsolete and cribriform hydatid cyst presenting a tough opaque yellow appearance. The contents of this cavity had probably escaped during the hurried division of the liver.

Remarks.—This case was one of extreme interest. A large hydatid tumour of the liver discharged its contents through the bile-duct into the bowel, and was undergoing a spontaneous cure, and the patient had almost regained his former health and was able to resume his business. A few cysts however remained in the cavity, and their occasional passage along the bile-duct gave rise to attacks of pain like that produced by a gall-stone. With the first attacks there was no vomiting, and the patient speedily recovered, but at last there came an attack characterized not only by pain but by violent retching. The straining caused by the vomiting led to a rupture of some of the adhesions between the diaphragm and the wall of the old hydatid cavity, and the result was a very circumscribed peritonitis and rapid sinking. That so small an amount of peritonitis should have proved fatal is itself a remarkable circumstance. The existence of a temporary obstruction of the bile-duct shortly before death is rendered probable by bile being found after death in the upper part of the small intestine, but not in the large intestines. The obsolete hydatid cyst was probably the source of the symptoms from which the patient suffered seven years before death.

The preparation is in the Museum of the Middlesex Hospital.

Dr. Murchison, *4th of April*, 1865.

V.—DISEASES, ETC. OF THE GENITO-URINARY ORGANS.

A. KIDNEYS, BLADDER, ETC.

1. *Dilated kidneys in a child. Congenital hydro-nephrosis.*

The child from whom the preparation (consisting of the kidneys, uterus, and bladder) was removed was between three and four months old. The abdomen had been large from birth, but urine had been passed, and, so far as was known, in the usual quantity.

She was brought to the Western General Dispensary, and was under the care of Mr. Anderson. A catheter was passed without difficulty, and some urine drawn off. Subsequently, frictions with iodide of potassium ointment were used, and were followed by the discharge of a large quantity of urine, and complete subsidence of the enormously enlarged abdomen. This effect was probably due rather to the pressure and friction than to the iodide.

On *post-mortem* examination the pelves of both kidneys were found

greatly distended and thickened, and the kidneys themselves expanded. The ureters were large and slightly sacculated. Their openings in the bladder would admit a full-sized probe, and fluid passed easily to and from the pelvis and bladder. The bladder was large and its walls thickened, but not proportionately with the kidneys. From these appearances it was concluded that the obstruction which had given rise to the distension was in the urethra, but this could not be demonstrated, as the urethra had not been removed.

Dr. W. H. Broadbent, 1*st of November*, 1864.

Report on the above specimen—As in this specimen the bladder was still attached to the kidneys by the ureters, the examination of the different parts was facilitated.

The bladder was found to be considerably dilated, and apparently to have lost much of its contractile power in consequence of prolonged over-distension.

The orifices of the ureters were large enough to admit the point of a good-sized knitting-needle, and were consequently readily seen by the unaided eye.

The ureters themselves were irregularly distended, so that when filled with water they looked almost sacculated. Water injected through them flowed up into the pelvis of each kidney—into the left with facility, into the right with difficulty. The pelvis of each kidney was much dilated—the right twice as much as the left; the former might hold seven or eight, the latter four ounces of liquid. The parenchyma of both kidneys was altered in form and condensed in consistence, almost fibrous to the touch, but this condition might in great part be due to the hardening in spirit.

No calculi or deposit of any kind could be detected in any part of the organs.

On examining the pelvic orifices of the ureters, the much greater dilatation of the right kidney was ascertained to be due to a circular fold of mucous membrane, which, until distended completely, blocked up the passage. It was close to the pelvic orifice and formed a perfect valve. Several imperfect valvular folds existed in both ureters.

The urethra being absent, the cause of obstruction to the outward flow of urine from the bladder cannot now be ascertained, but as no stone or gravel existed in any of the parts examined, and as the obstruction in the ureters appears to have been caused by folds of

mucous membrane, it is not improbable that a somewhat similar state of things existed in the urethra. If so, the urethral valve, when distended to a certain point, must have allowed of the daily passage of a portion of the accumulated urine, otherwise the child could not possibly have lived so long as it did (three months). Moreover, the condition of the kidneys leads to the belief that the obstruction was congenital.

Dr. G. Harley,
Dr. W. H. Broadbent, 15*th of November*, 1864.

---

2. *Atrophy of kidney and supra-renal capsule.*

This kidney and supra-renal body were exhibited on account of their exceedingly small size. The kidney was of the usual form, but only about three-quarters of an inch in length. One or two minute cysts were seen, but the surface generally was smooth, and the capsule was easily stripped off. On section it presented miniature pyramids, with cortical substance; the pelvis and ureters, renal artery and vein, were on a correspondingly small scale.

The supra-renal capsule had the form which this body usually presents, but was exceedingly small.

The woman from whom the preparation was taken died with symptoms of uræmic poisoning, and the other kidney was small and granular. At first sight it was supposed that this was an extreme condition of the same disease, but the details given show that the atrophy was congenital. Dr. W. H. Broadbent, 1*st of November*, 1864.

---

3. *Kidneys with so-called fibrinous deposits, from embolism of the renal arteries, connected with mitral disease.*

The patient, a woman, æt. 26, had been admitted under Dr. Hermann Weber's care, into the German Hospital, on October 3rd, with old mitral disease and pulmonary apoplexy. On October 5th she was suddenly seized with violent pain in the right side, just below the twelfth rib, along with great collapse, vomiting, and diarrhœa, the pain being increased by pressure. These symptoms abated after about two days. On October 12th a similar but still more violent attack occurred, the pain being this time on the left side, lasting almost a week with varying intensity, and being only relieved by frequent subcutaneous injections of

morphia. The urine, which had exhibited only a very small quantity of albumen before these attacks, became highly albuminous during and for about a fortnight after this occurrence, containing many tube-casts of various kinds, but principally of the transparent variety; from the end of October, however, until the time of death, the urine was free from albumen and casts. Traces of blood only had existed during a few days at the time of the attacks. Anasarca of the lower extremities, which had been moderate before the attacks, but much increased immediately after them, diminished again with the disappearance of the albumen from the urine.

There was intense icterus during the last fortnight.

Death occurred, from pulmonary apoplexy and pleuritic effusion, on November 11th.

The *post-mortem* examination manifested mitral stenosis, with roughness of the edges of the very narrow oval-shaped opening, and great dilatation of the left auricle; there was also moderate contraction of the tricuspid orifice (from adhesion between two of the folds, and slight thickening of all three), and corresponding dilatation of the right auricle. The right lung exhibited the products of pulmonary apoplexy in various stages of progress, and the right pleural cavity was filled with sero-purulent fluid. The mucous membrane of the small intestines was swollen, closing the opening of the gall-duct. Liver of nutmeg appearance, with commencing atrophy; the tissue very tense. Spleen likewise hard and tense, as also the supra-renal capsules. The right kidney contained in the centre a pale yellowish deposit, shrunk, and depressed below the surface of the surrounding tissue; the left kidney contained several larger deposits likewise of pale yellow colour, but slightly raised above the level of the surrounding normal tissue; the deposits occupied the greater part of the upper portion of the kidney; the corresponding artery was obliterated by an old fibrinous plug, while the artery supplying the normal portion was free. The plug in the obstructed branch of the artery was slightly adherent to the walls; it could, however, be separated without injuring them; it did not obstruct the whole length of the branch, but terminated at two ramifications rather abruptly, leaving the remainder free.

Dr. Weber remarked that, amongst the many points of interest the case showed the embolic nature of the so-called fibrinous deposits of the kidney, by the presence and the characters of the plug in the upper branch of the left renal artery; that it further elucidated the

symptoms of embolism of the kidneys, which affection in this instance had been diagnosed by Dr. Baeumler, the resident physician of the Hospital at the time of the occurrence; and that it manifested also the changes taking place in these "deposits," that in the right kidney having occurred thirty-eight days before death, being already shrunk below the level of the surrounding tissue, while the "deposits" in the left kidney, having occurred between a week and a fortnight later, were still slightly prominent above the level of the surrounding tissue, but without the elevated red margin seen in still more recent cases.

The time of the Society being much occupied, Dr. Weber did not enter into the description of the microscopic appearance of the deposits.

Dr. Hermann Weber, *6th of December*, 1864.

---

4. *The urine of intermittent hæmaturia.*

The specimens of urine shown to the Society were passed by a man, æt. 32, who during the last two winters had voided bloody urine whenever he was exposed to cold.

The peculiarity of these cases is that the appearance and properties of the urine vary in a marked degree at different hours of the day. Thus, if the morning's urine only were to be brought under the notice of the physician, he could not from it suspect the existence of any urinary affection; whereas, if the mid-day's urine had alone been subjected to his inspection, he could not fail to suppose that the patient laboured under some severe organic changes in the renal organs. Yet neither of these opinions could possibly be correct.

Dr. Harley then pointed out the difference between the urine of ordinary hæmaturia and that of the intermittent variety. In ordinary hæmaturia, the urine is not only coagulable by heat and nitric acid, but contains blood corpuscles, which are gradually deposited on standing; while in this form of intermittent hæmaturia, as in some cases of the non-intermittent variety, the urine, although coagulable by heat and nitric acid, contains no blood corpuscles, and the colouring matter is not deposited on standing. Besides this, the urine contains numerous granular tube-casts, an increased per-centage of urea, and a deposit of amorphous urates. Dr. George Harley, *20th of December*, 1864.

---

5. Case of malformation of the bladder.

Mr. Holmes exhibited the urinary organs from a male infant, æt. eight days. When born, it was noticed that the delivery of the trunk was somewhat tedious, though that of the head was easy; and on examining the child, Dr Traquair, who was in attendance, discovered a remarkable peculiarity in the shape of the abdomen, and he also noticed that the testes were retained and imperceptible. The child was otherwise well formed, and was above the usual weight. The only other peculiarity was that the region of the pubes was covered with a diffused nævus, or mother-stain. The mother was a lady about 40 years of age, who had previously borne four healthy children.

Mr. Holmes saw the infant when three days old. There was then an ill-defined swelling of the lower part of the abdomen, causing a great amount of "swag-belly;" but the head, limbs, and chest were well formed, and the child well nourished and lively. On examining the abdomen, it was plain that the protrusion was formed by the intestines which had become prolapsed, as it were, in consequence of the deficiency of the muscular parietes. There was no increase (rather a diminution) in the extent of the hepatic resonance, nor could any tumour be discovered in the splenic or renal region. The coils of intestine could be plainly felt and seen under the skin in two large masses on either side of the middle line, but in the middle line the parietes appeared to be firmer, and there was no distinct protrusion, though the whole of the lower part of the belly was more prominent than natural. It being assumed, then, that the cause of the shape of the abdomen was the deficiency of its muscular parietes, the next question was whether there was any tumour pressing the intestines forwards. Nothing of the sort could be detected in the iliac or lumbar regions; the abdominal viscera, as stated above, were healthy, so far as could be ascertained, and the urinary function and secretion were natural; the bowels also were natural. Nothing could be suggested beyond supporting the parietes of the belly with an elastic belt.

For the next two days the child continued to thrive pretty well but then began to refuse the breast, and sank gradually. Shortly before death it was noticed that a great deal of water had been passed, and that it was tinged with blood. It should be mentioned that on one former occasion it was thought that there was a tinge of blood in the urine, but this was not proved. On *post-mortem* examination, the

intestines were found to be immediately below the skin of the abdomen, only slight traces of the muscular parietes being found here and there. The precise arrangement of these muscular fibres was not traced. Nothing abnormal was found except in the genito-urinary tract. The testicles were situated close below the kidneys. The kidneys were both somewhat absorbed by pressure, particularly the left, in which little of the renal structure remained. The ureters were correspondingly distended and tortuous. The bladder presented a remarkable malformation. It consisted of two distinct sacs, one of which was proved to be the true bladder, since it presented the openings of the ureters and urethra, all of which were pervious. The parietes, however, of this sac were excessively hypertrophied, and about three times the natural thickness. This seemed to depend mainly on over-development of the muscular fibres; but there were besides, immediately under the mucous membrane, a large number of villous prominences of a dark purple hue, consisting on section, not of extravasated blood, but of vascular tissue, like that of nævus, and probably constituting a nævus of the vesical mucous membrane corresponding to the nævus of the skin of the pubes. The other sac lay in the right side of the pelvis and adjacent part of the iliac fossa, and at the *post-mortem* examination appeared to be immediately under the skin. It had not however been felt during life, being probably masked by the intestines falling down in front of it. It was rounded, and about the size of the true bladder, with which it communicated by an opening about half-an-inch in diameter. Its coats showed no trace of muscular fibre, but were throughout thin and membranous, nor was there any trace of vascular tissue on its interior. The contents of this malformed bladder were found to be healthy urine, containing a slight tinge of blood uniformly diffused through the fluid.

The whole mass formed by the bladder had evidently pressed backwards on the ureters, thereby causing distension of the kidneys, which seemed to be the proximate cause of death.

The malformation is a remarkable one, and appears not to have been previously met with, at least it is not described in the standard works on this subject. The urachus was perfectly closed, and the adventitious cyst lay quite away from the position of this tube. Besides, the malformation of the true bladder appeared to consist rather in an excess than a deficiency of development.

In a practical point of view, it seemed theoretically possible, that if

a catheter had been kept in so as to keep the bladder permanently empty, the infant's life might have been prolonged; but there was nothing to indicate such a course, since the urine passed in natural quantity; and it is after all doubtful whether the presence of the foreign body in the bladder would not have increased the hæmaturia, which seemed to depend on congestion of the nævus-tissue. The preparation is in St. George's Hospital Museum.

Mr. Holmes, 17*th of January*, 1865.

---

6. *Medullary tumour of the kidney.*

Mr. Smith exhibited, for Mr. Marsh, a tumour, weighing eleven pounds, which had been removed from the body of a male child, who died at the age of 19 months.

This had been first noticed, when the child was three months old, as a mass about as big as an orange, lying in the region of the left kidney. Subsequently increasing rapidly in size, it soon caused enormous enlargement of the belly, and by pushing up the diaphragm encroached considerably on the cavity of the thorax.

Although the disease made very quick progress, it was not accompanied by any special cachexia, and appeared to have no influence on the general health, until the tumour, by its immense size and weight, interrupted the functions of the abdominal viscera: after this was the case, however, the child was slowly reduced to a state of extreme emaciation, and died at last of simple inanition.

At the *post-mortem* examination, the tumour was found to be situated behind the visceral layer of the peritoneum, which was stretched over its anterior surface, giving it a smooth polished appearance. It was invested by a distinct capsule, and had formed no connection, either by adhesion or infiltration, with the surrounding parts. It had evidently originated in the substance of the left kidney, the remains of which, unaltered in structure, were found spread out into a thin layer over its posterior surface; the ureter was quite normal. No affection of the lymphatic glands was discovered. The remaining viscera were healthy. In general outline the tumour was egg-shaped. On section, it was found to contain numerous cysts embedded in a coarse fibrous or reticulated structure, the meshes of which were in some parts occupied by a gelatinous material. The cysts were of various sizes, and the larger ones contained

others of smaller dimensions springing from their inner surface. Some were filled by growths of solid substance. The microscopic structure was seen to be of a fibro-cellular nature, the cellular element predominating in some portions.

Mr. T. Smith, 17*th of January*, 1865.

---

7. *Case of calculus adhering to the mucous lining of the bladder.*

A girl died of typhus fever in the Royal Infirmary of Aberdeen, who had long suffered from urinary symptoms. A *post-mortem* examination was made by Dr. Keith, who found a stone adhering to the mucous membrane; he removed it with some force, and left the bladder behind. The stone is a flat oval in form, measures one inch and a-half by one inch and an eighth, and is composed of uric acid and urates; one of its surfaces has a large patch of phosphatic deposit, very porous in its structure, corresponding with the site of its attachment to the bladder.

I had been corresponding with Dr. Keith on the subject of the adhesion of stones to the bladder, being assured of the extreme rarity of such a condition. He was good enough to send me the stone, and a letter describing the condition found. The following extract from the letter will explain his experience of the subject better than any words I could use, and I therefore beg leave to subjoin it:—

"And now as to inorganic bodies adhering to living tissues. Vital union in its perfect sense is impossible; but this I am prepared to affirm, that a porous cancellated inorganic structure, pressed continuously against a soft living tissue, may have its pores, fissures, and inequalities so filled by elevations, processes, and plastic effusion arising from prolonged irritation, as to become adherent and pendant from the surface to which it has so long been pressed. Take a piece of sponge and press it on the surface of a chronic ulcer, bandage it there for two or three days, and on withdrawing it you will cause much pain and no little hæmorrhage from the tearing of many processes of granulation that had protruded into the pores of the sponge, thereby making it adherent to the living surface of the ulcer. I mean no more when I speak of a stone adhering to the coats of a living bladder.

"No doubt a secreting mucous surface is inimical to any such occurrence, but constant pressure oft repeated, and hard straining in micturi-

tion, may cause ulceration of the mucous membrane, and plastic exudation, and then the chief hindrance is removed. All this is possible; but I frankly admit my conviction to be that it is a *most unusual occurrence.* I have no reason to think that I ever met with it but in two cases, in the living subject, out of one hundred and ninety-six lithotomy cases, and never in one hundred and twenty lithotrities; and in the two cases referred to, the belief, or suspicion let me call it, was more based upon the pulpy flocculent appearance of living-like tissue adherent to a portion of the calculus, seen immediately after its removal from the bladder, and in both cases limited to a portion of the surface, thickly coated with a porous phosphatic deposit (the tissue referred to seemed also to hold blood), than to any difficulty presented by the so-called adhesion of the stone in its removal from the bladder; any such hindrance behooved to be very trifling, but not so the firm, long-existing contraction of the bladder, occasioning, at least accompanying, such an accidental occurrence. So much for my living experience; it cannot be called very extensive, neither very conclusive. But that such an adhesive process can and does sometimes take place I can prove by one *post-mortem* inspection. A girl came into the Hospital with typhus fever, having been for long affected with symptoms of urinary irritation, as reported. She died; and on opening her bladder I found the stone I now send you for inspection adhering firmly to the fundus of the bladder, and pendant therefrom by the white surface you will notice on the side and end of the stone. At the moment, I did not advert to the value of the preparation before me, and as the inspection was without leave, I tore the stone from its attachment, and left the bladder behind. I have never met with another such."

I may add that in the sixth volume of the Society's *Transactions* an admirable illustration of this condition will be found. It was discovered in the dissecting-room of the Middlesex Hospital, and was exhibited by Mr. Shaw. In that case, two uric acid calculi were found very closely adherent to the bladder by the interlacing of organic fibres with the outer coat of the concretion. A second case, but less marked, is recorded in the ninth volume, exhibited by Dr. Van der Byl. These are the only instances of dissecting-room observations in the *Transactions* besides the present case.

Mr. Thompson, *7th of February*, 1865.

8. *Hair-pin removed by the high operation from a girl's bladder.*

A girl, æt. 13, in the latter part of December, introduced a hair-pin into her bladder. She was examined by two or three gentlemen in the country, and the presence of the pin verified. It appeared not to be readily removable, and they decided to send her up to University College Hospital, to be placed under Mr. Thompson's care.

She made a journey of one hundred and fifty miles without much uneasiness, and her symptoms were by no means severe after her arrival.

I examined her in three or four days, and found such a body as that described, but apparently in a fixed position. On the 11th of January, 1865, exactly fourteen days after the introduction of the pin, she was placed under chloroform, and a lithotrite introduced. The pin was seized, but appeared immovable; it would not turn on its axis, or laterally. Mr. Erichsen and I examined both by vagina and by rectum, and we agreed that the pin was felt firmly embedded between those parts and the left side of the pelvis, and that the head of it was distinguishable above the pubes. It was agreed that the high operation was the only safe course to be employed; accordingly with my colleague's assistance I at once performed the operation.

The pin was found lying as described, and was removed without difficulty by traction upwards.

It was a very stout hair-pin, three inches in length. The patient had given me three similar pins before the operation, and having experimented upon them in various ways, I found them too tough and large to be cut in pieces *in situ*, or dealt with as in other methods which would have been applicable had the pins been of the usual thickness and flexibility.

The patient is doing extremely well.

Mr. Henry Thompson, *7th of February*, 1865.

---

9. *Intermittent hæmaturia.*

The case of the patient from whom the urine shown was obtained, was detailed before the *Medico-Chirurgical Society*. It is sufficient to state here that the patient was a working man, who had short attacks of hæmaturia after every exposure to cold. The passing of the blood was always

preceded by constitutional symptoms—rigors, vomiting, pain in the loins, and a disposition to stretch himself. When these symptoms had made themselves evident, the urine for two or three urinations contained blood. Some which had been passed during a recent attack was brought before the Society. It was black, turbid, and highly albuminous. It contained no blood corpuscles, but a quantity of yellowish molecular deposit, probably the product of their disintegration. Many small granular casts of the kidney tubes were seen. The urine during these attacks always contained a great excess of urea. (For details, see *Med. Chir. Trans.*, vol. xlviii., 1865.

Dr. Dickinson, 21*st of February*, 1865.

---

10. *Psoas abscess depending upon tubercular abscess in the kidney.*

A man, æt. 22, was admitted into St. George's Hospital, under the care of Mr. H. Lee. He had an abscess in the groin which appeared connected with the psoas muscle, and was attributed to disease of the spine. The discharge became at last very profuse; his legs and feet became anasarcous; he gradually sank, and died. He had been under treatment in the Hospital for nearly a year, the disease having existed for a long time previously.

The case was looked upon as one of common occurrence, and the notes of it were rather incomplete.

At the *post-mortem* examination, a small opening, from which pus exuded, was seen in the left groin. The leg was œdematous, permanently bent, covered with an erysipelatous blush, and traversed by conspicuous veins. The femoral and the other veins of this limb were found to be full of partly decolorized and softened coagulum. The coats of the femoral vein were thickened, and the vessel was adherent to the surrounding tissues. The abscess was in close relation to its outside, and seemed to have caused some inflammatory action in the wall, which had led to the coagulation of blood. The abscess, which opened in the manner described, was traced up through the psoas muscle to the left kidney, which was distended with pus and tubercular matter. The organ on section proved to consist of a mere cyst, divided into compartments. The cavity was distended with thick purulent matter, and was lined with a layer of crude tubercle. Two openings existed on the posterior and lower part, through which a bougie could be passed into the interior of the organ; one of these was continuous with an opening on the front of the psoas

muscle. The opening in the kidney was round; it had definite edges, and was about as large as a sixpence. The kidney, with its contents, weighed one pound thirteen ounces and a-half. There was no communication between this abscess and the spinal column. Nevertheless it was discovered that the bodies of two or three of the lower dorsal vertebræ were carious, but the disease was confined to their right sides. There was a little pus in this situation under the periosteum, and some had penetrated a couple of inches into the right psoas muscle. Both lungs contained crude and miliary tubercle. There were some small recent deposits of fibrin on the inside of the mitral valve.

The right kidney, the liver, the spleen, the mucous membranes of the small intestine, and the mesenteric glands, were all in a state of "amyloid" or "lardaceous" infiltration.

Remarks.—I am not aware that psoas abscess has before been traced to renal disease. The diagnosis in this case was obscured by the existence of caries of the spine, though on the opposite side of the column. The course of the disease appears to have been much what it would have been had the matter come from the spine. The urine was never examined.

The case affords an instance of a general state of amyloid or lardaceous infiltration, as the result of long-continued suppuration.

Dr. DICKINSON, *21st of February*, 1865.

---

11. *Pink lithate deposit.*

Lithate deposits of a truly pink colour are so rare that Dr. Prout states, in his work '*On the Stomach and Renal Diseases*,' that in an experience of thirty years he had not seen "a dozen well marked cases." The specimen exhibited was a very bright pink. It was from urine passed by a gentleman presenting symptoms of chronic hepatitis, and it tends to confirm Dr. Prout's statement that "pink sediments usually indicate the presence in the system of certain chronic visceral affections, especially of the liver and spleen."

Dr. LEARED, *7th of March*, 1865.

---

12. *Suppression of urine for ten days. The left kidney destroyed, and its ureter impervious; right ureter plugged up at its extremity.*

T. B., æt. 62, a house-painter, who had not escaped repeated attacks

of colica pictonum, had been in the habit of taking spirits in moderation.

Some twenty years ago, according to his wife's report, he was the subject of dropsy and general anasarca, and was told that he would always be liable to it. With the exception of occasional attacks of dizziness during the last few months, he remained well, in his own estimation, until January, when suppression of urine took place for three days, with constipation of the bowels. He was relieved after taking saline purgatives. This occurrence caused his family the less uneasiness as he would frequently remain about eight hours without voiding urine; at other times he would micturate at short intervals, especially at night-time. He had never had stricture, nor had he been known to suffer from stone.

On Saturday, February 11th, he voided with difficulty about a cupful of urine the colour of blood. Then suppression set in. At the end of four days he applied for relief at the Western General Dispensary. Mr. Shone found the bladder empty; there was no desire to micturate. Next day (16th) the bladder was again explored by Mr. Anderson with the same result. The patient had become drowsy, and there was ptosis of one eyelid, and some nausea. The pulse was 84. Purgatives, emetics, and small doses of tinct. cantharidis were given.

On the 19th (eighth day), he first experienced a desire to make water, and is reported to have passed half a pint of limpid urine. There is, however, reason to doubt the correctness of this statement. On the ninth day, my attention was called to the case. I found the patient, a robust man, propped up in bed, breathing hurriedly. His manner was anxious; he was very restless; drowsiness had passed off; there was great muscular debility and subsultus; the pupils were contracted. He answered questions readily, and stated that he had a sensation of dizziness; also that he suffered from a tensive heavy feeling, not amounting to pain, in the situation of the right kidney. The pulse was very irregular, and beat from 52 to 56 per minute; the heart sounds were laboured; the tongue sticky and coated; the skin cold, clammy, and of a leaden hue; the abdomen tympanitic. He had retched and vomited on two or three occasions; there had been two unformed dark motions during the day.

During the following night he slept at intervals, but his restlessness became extreme; he made frequent attempts to micturate, and voided only a few drops of blood.

These symptoms increased: his consciousness remained entire up to the time of his death, which occurred very quietly at 6 P.M. on the 21st, the tenth day from the commencement of the attack.

At the *post-mortem* examination, the body was found to be that of a muscular man. The arcus senilis was strongly marked. The dura mater adhered firmly to the calvarium. The brain substance was firm, of a dirty reddish colour. The lateral ventricles contained nearly an ounce of blood-stained fluid. The posterior and middle cerebral arteries were atheromatous.

The several serous cavities contained turbid fluid, which, with the exception of that in the pericardium, was of a reddish tint. The blood was dark-coloured, and fluid. The heart was healthy; the left ventricle contracted.

The left kidney was much shrunken, and appeared to be reduced to an aggregation of cysts with tough fibrous walls; no true kidney substance, whether cortical or medullary, was distinguishable. The smaller cysts contained clear fluid, while that in two much larger ones was thick and white, and resembled chalk mixture, an ounce and a-half in quantity. This white fluid contained much cholesterine, numerous plates of which were seen under the microscope, together with amorphous granules, probably phosphate of lime. The fluid was neutral to test-paper. Heating on platinum-foil left a considerable amount of white residue, which effervesced considerably with hydrochloric acid. A solution gave a white precipitate with ammonia, showing the presence of phosphoric acid.

The kidney weighed two ounces. A small calculus was impacted in one infundibulum. The ureter was impervious in its whole course; no trace of its proper orifice could be detected on the inner surface of the bladder.

The right kidney was large, its weight seven ounces. The capsule could be separated readily, leaving a smooth surface beneath; four or five cysts were visible, the largest the size of a bean; the organ appeared congested, while its structure generally was healthy. Examined microscopically by Dr. Bristowe, some of the malpighian bodies appeared to be contracted, and to have thickened capsules. The walls of the uriniferous tubules were also thickened, and their epithelium was more granular and less distinct than usual; a few contained probably blood.

Many of the tubes in the apices of the cones appeared to be blocked up with refractive cylindrical masses, which were moulded to their shape, and did not polarize light. Here and there were appearances of microscopic cysts, which, however, might have been merely sections of dilated tubes. The mammillary processes were compressed, the calices dilated; a diverticulum, which admitted the entrance of a probe, terminated near the surface in a small pouch. The infundibula, the pelvis, and the ureter were dilated, and contained some urine. The bladder when laid open was found empty; the orifice of the right ureter was found to be entirely blocked up by a dark-coloured plug, slightly rough to the touch, but not hard, being partly broken down by pressure between the fingers. Under the mucous membrane of the bladder, surrounding the orifice of the ureter, there was sanguineous discoloration, and in another part of the bladder enough blood had been extravasated to form a clot the size of a bean.

It was thought that the plug probably consisted of a rounded calculus of uric acid which had been broken down, or of a series of smaller calculi connected together by blood. Under the microscope, fragments of concentric laminæ and large numbers of crystalline fragments were seen, many of which were of an elongated lozenge shape, with rounded angles. Small portions of the mass were found to dissolve in nitric acid with slight effervescence, but the addition of ammonia to the reddish residue, on evaporation, failed to produce the characteristic murexide.

The prostate gland and the vesiculæ seminales were enlarged. The other organs of the body were healthy.

Dr. Bagshawe, *7th of March*, 1865.

---

13. *Calculus from urinary bladder removed by lithotomy, having a blood-clot nucleus.*

The calculus was composed of phosphates, and was one inch and five-tenths in its longest, and one inch and two-tenths in its shortest, diameter. The nucleus, which was very distinctly marked, was five-tenths of an inch in its longest, and three-tenths in its shortest diameter.

The patient from whom it was removed had long suffered from stricture of the urethra, and had undergone various operations for its

relief without effect, until the stone was discoverd and removed. Age of patient, 48. Mr. Nunn, 21*st of March*, 1865.

---

14. *Tuberculous disease of the kidney.*

The patient from whom this tuberculous kidney was taken was a merchant, of small stature, and pale and thin appearance, æt. 29. He first came under my observation in August, 1864, having then suffered for several months from constitutional disturbance, such as disordered stomach, &c. Latterly his urine had been offensive, and he had been unable to retain it; he was obliged to wear an Indian-rubber urinal. He complained of no pain, but admitted feeling some uneasiness in the left loin.

The urine was loaded with pus, but contained no more albumen than was due to the presence of the pus. A stricture of the urethra, two inches from its orifice, prevented the introduction of an instrument into the bladder. After a short time this difficulty was overcome, and the bladder carefully sounded. No stone could be detected, and it was thought the case might prove to be abscess of the prostate. He then left town, but returned in a month, exhibiting a considerable tumour in the left loin, with a dull heavy pain there; this was evidently an abscess. By the end of October the fluctuation was so evident that it was deemed advisable to open it, and a pint of greenish pus was evacuated. The discharge continued to flow, and the tumour, which had extended anteriorly to the epigastric and inferiorly to the iliac regions, entirely disappeared. The incontinence of urine and its purulent condition, however, continued without change; emaciation proceeded to an extreme degree; uncontrollable diarrhœa set in during the last three weeks, and the patient died on March 14th, 1865.

Post-mortem examination showed all the other organs healthy, except the left kidney; this was enlarged, and the whole of its internal structure reduced to a mass of tuberculous abscesses which were pointing in numerous places on its surface. Anteriorly it adhered firmly to the colon, and one of the abscesses had burst into its cavity. Posteriorly it was also adherent to the surrounding tissues, and the sinus which remained open in the loin could be traced into one of the tuberculous cavities. Dr. Thomas Ballard, *4th of April*, 1865.

---

15. *Case of wasted kidney, from malformation of ureter.*

The kidney exhibited was the left, and its secreting substance had almost entirely wasted, owing probably to the opening of the pelvis into the ureter not being at the apex of the pelvis, but at one side, so as to give rise to a sort of valvular aperture, very unfavourable to the passage of urine.

The other kidney was about the natural size, and diseased.

This condition of things was quite unsuspected during life. The woman (æt. 39) died of bronchitis and gangrene of the lung.

Dr. Julius Pollock, 18*th of April*, 1865.

---

16. *Numerous spherical calculi passed by the urethra.*

The calculi numbered three hundred and upwards. The size of the largest was rather under two-fifths of an inch in diameter. The greatest number were not larger than white poppy seeds, or dust-shot, but every intermediate size was represented by single specimens. They consisted of lithic acid and lithate of ammonia, and had apparently lain in the kidney for a considerable period, several presenting polished facets, the result of mutual attrition. The patient was a gentleman, æt. 77, who, during the passing of the calculi, which occupied about two months (February and March, 1865), suffered a considerable degree of irritation of the bladder, from which, however, at the present date, May, 1865, he has quite recovered.

Many of the calculi passed spontaneously through the urethra; the remainder were removed by washing the bladder with a large-eyed catheter.

Mr. Nunn, 2*nd of May*, 1865.

---

17. *Urine containing a large quantity of colouring matter resembling indigo.*

A girl died in St. George's Hospital, in consequence of a perforating ulcer of the stomach, which had caused a very large circumscribed abscess in the peritoneum. The amount of pus contained amounted to at least two quarts.

It was found by Mr. Heywood Smith, on the day before her death, that

the urine turned deep blue on the addition of hydrochloric acid, and Dr. Dickinson received about six ounces of the fluid for examination.

It was, when passed, of a pale yellow or citron colour. It contained no albumen or sugar, was acid, and but for the especial test applied would have passed for natural. Under the miscroscope many minute bodies were found that exactly resembled rice-starch, which it is possible they may have been; they gave the characteristic reaction with iodine.

The quantity of urine obtained (six oz.) was mixed with an equal quantity of strong hydrochloric acid and left alone for several days. A blue-bronze pellicle had been formed upon the surface which was skimmed off. The colour was destroyed by nitric acid, but was not affected by liquor potassæ. In these respects the substance resembled indigo.

Besides this, a copious indigo-coloured precipitate had fallen, leaving the fluid of a reddish purple tinge. The fluid was carefully removed by decantation, and the precipitate, which had a reddish tinge mingled with the blue, was repeatedly washed with alcohol until the fluid came away without colour, leaving a dark blue powder which spirit did not affect. The earlier washings were of a bright pink colour, so that finally about three ounces of alcohol were obtained which had a bright magenta tint; this was perfectly dissolved in the spirit. The washings now began to assume a violet colour, and ultimately about the same quantity of a rich violet solution were obtained.

The blue powder which remained had, when dry, exactly the appearance of indigo. The quantity obtained weighed ·014 grains. A good deal however was lost in preceding experiments. The colour was at once destroyed by nitric acid. It was soluble in strong hot sulphuric acid, without any change of tint; and a solution was obtained which was miscible with water in any proportions, and was enough to give an intense blue colour to three or four ounces of water, the fluid being almost opaque from the intensity of the colour.

The powder was soluble in ether. By moderate heat, about that of boiling water, the blue powder turned dark brown, and volatilized in visible fumes.

All the chemical reactions are those of indigo blue; it is scarcely possible to doubt that it is veritable indigo. The separation first of all of a red pigment soluble in alcohol, which may be considered as indigo red, furnishes another argument, if one be needed.

It has long been known that indigo, or something closely allied to it, occasionally exists in the urine; but I do not think that it has ever been described as existing in anything like the quantity here present.

As to the pathology of its formation, we must confess our ignorance. Dr. Parkes, among other conditions in which the pigment had been found, mentions a case of perforation of the bowels, and another of strumous peritonitis. Whether the disease in these cases, or in the case before the Society, had any connection with the formation of the indigo, must be left uncertain. Dr. Dickinson, 16*th of May*, 1865.

---

18. *Intermittent hæmaturia.*

Three specimens of urine, from the same patient, were exhibited, passed on the 9th, the 16th, and the 23rd of May, 1865. The first and last were perfectly limpid, rather pale, with no deposit on standing, and yielding not a trace of albumen when treated with heat and nitric acid. The second specimen, passed on May 16th, was of a dark, reddish-brown hue, as if from blood. It threw down, on standing, a copious reddish-brown sediment, and when boiled yielded an abundant coagulum, which was partially re-dissolved by nitric acid. The patient was a man æt. 30, who came as an out-patient to Dr. Murchison, at the Middlesex Hospital. He stated that for upwards of six months his urine had often been dark like porter, and after a few days, without any treatment, had become quite clear again. He could not attribute the attacks to any cause such as cold or wet, but he always knew when one was coming on by having "a cold shake all over." He had never suffered from ague, nor lived in a malarious climate.

Dr. Murchison, 16*th of May*, 1865.

B. MALE GENITAL ORGANS.

19. *Fibrous tumour of the scrotum, involving the left testicle.*

The tumour was successfully removed (with the testicle) by Mr. Heath, from a man, æt. 56, who had noticed an enlargement of the scrotum for thirteen years, during which time he had suffered no inconvenience, except latterly, from the size of the growth. He had married since the tumour first appeared, and had three children. Six

weeks before admission into the Westminster Hospital, the skin over the lower part of the tumour gave way, and he lost a good deal of blood, and a sanious discharge continued, which exhausted him a good deal. The scrotum measured fourteen inches in circumference, but this was due in part to a hydrocele of the left testis. At the operation the tumour was found to be connected with the back of the testicle, which it was necessary to remove with it. The spermatic cord was perfectly healthy, and the patient made a good recovery.

The tumour was connected with the areolar tissue of the cord, and was closely attached to the back of the epididymis and the tunica vaginalis. On section, it presented the ordinary appearance of a fibrous tumour, and this was confirmed by microscopic examination. The tumour was hollow, and the interior was in a sloughy condition, and communicated with the opening in the scrotum, the skin being adherent around the orifice.

Mr. Christopher Heath, 1*st of November*, 1864.

---

20. *Case of milky fluid from the tunica vaginalis. Galactocele.*

The fluid exhibited presented all the physical characters of ordinary milk, and was obtained by tapping from the tunica vaginalis. The patient was a German, æt. 42, a healthy-looking man. He had been thrice tapped within the last twelve months, and similar fluid had been drawn off on each occasion. In all its external characters and in its history, the case resembled ordinary hydrocele. Fluctuation was so palpable that no examination to ascertain transparency was made. In all his experience, Mr. Fergusson had never met with a similar case. By way of comparison, the clear fluid from an ordinary hydrocele was also exhibited. Mr. W. Fergusson, 6*th of December*, 1864.

Report on the above specimen.—Before giving the results of the microscopical and chemical analysis of this equally rare and interesting liquid, your reporters deem it advisable to mention that the specimen under consideration cannot be regarded as perfectly unique, for at least two similar cases have already been published. One of these is ably reported in Vidal's work on *Surgery* (vol. v., p. 176). The fluid in that instance was removed by M. Vidal from the tunica vaginalis of a French soldier, whose case presented no further peculiarity than the unusual lactescent appearance of the liquid. The second case

DESCRIPTION OF PLATE VII.

A. illustrates Dr. George Harley's report of Mr. Fergusson's case of Galactocele (p. 184).

Fig. *a*. shows appearance of fluid when first examined.

1. Small globules of oil with albuminous coating.
2. Large granular cells filled with fat-globules.

Fig. *b* shows appearance of fluid ten days later.

1. Large oil-globules.
2. Stellate crystals of margaric acid.

B. illustrates Dr. Greenhow's case of Addison's Disease of the Supra-renal Capsules; from drawings by Dr. Burdon Sanderson (p. 247).

Fig. *a*. shows oval and round nuclei embedded in a finely granular stroma from the pinkish semi-translucent portion of the capsule, after addition of weak acetic acid.

Fig. *b*. shows connective tissue from the same part of the organ, after addition of acetic acid.

Fig. *c*. shows the same treated with water only.

C. illustrates Dr. George Harley's Description of Blood-Crystals (p. 272).

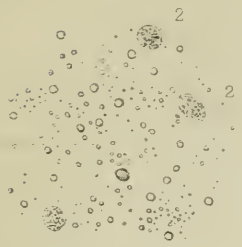
Fig. *a*. shows crystals of hæmatoidin.

1. In natural state.
2. Treated with caustic potash.

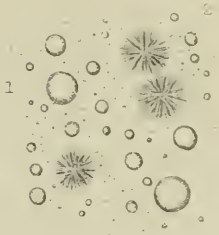
Fig. *b*. Crystals of hæmin.

Fig. *c*. Crystals of hæmatin.

A



a

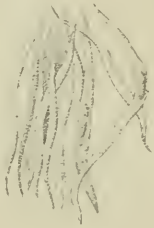


b

B

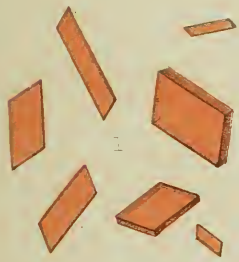
a

b



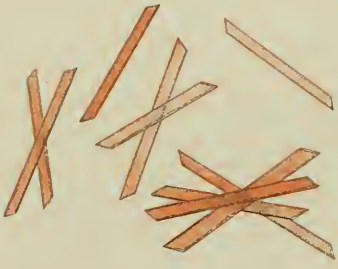
c

C.



a

b.



c

is also alluded to in Vidal's work, as having been recorded by M. Sichel, in his *Thesis*, presented to the University of Zurich in 1833.

The specimen examined by your reporters may be described as follows:—In quantity it measured five ounces; in reaction it was alkaline; and in appearance it so closely resembled ordinary cow's milk as to be undistinguishable from it by a mere naked eye inspection. The liquid, however, had a specific gravity of 1019, thereby differing very materially from milk, the specific gravity of which is in general about 1030. It had a very peculiar odour, which, on analysis, was found to be due to the presence of sulphuretted hydrogen. This gas was evolved in such quantity that white paper moistened with a solution of acetate of lead, was rapidly turned black when suspended for a few seconds over the surface of the liquid. In no other respect did the specimen present signs of decomposition, notwithstanding that fifteen days had already elapsed since its withdrawal from the body.

The milky appearance of the liquid was found to be due to the presence of fat, for on shaking up a portion of it with ether, the ether dissolved out a quantity of oleaginous matter, and left the liquid perfectly transparent, and of the ordinary colour of hydrocele fluid.

Heat and nitric acid, either separately or combined, caused a copious coagulation to take place, thereby indicating the presence of a large quantity of albumen.

The aqueous part of the liquid, after being carefully freed from protein matter, was found to contain sugar,—becoming brown when boiled with potash, and with Trommer's test depositing the sub-oxide of copper.

On further analysis, the specimen was ascertained to consist in one hundred parts of—

Water	87·870
Organic matter	10·935
Inorganic matter . . .	1·195
	100·000
Total solids	12·130

Although the organic matter chiefly consisted of albumen, there was along with it 1·53 per cent. of fatty matter, a little sugar, and a small proportion of a protein substance resembling casein in its reaction. The inorganic ingredients on the other hand were found to consist of

lime (= 0·253 per cent.), soda, and potash, in combination with phosphoric, sulphuric, and hydrochloric acids.

Microscopical examination of the liquid.—When first examined, the specimen was found to consist of innumerable small globules (Plate VII. A, Fig. *a*, 1) floating in a colourless fluid; the globules appearing to be composed of oil, coated with albumen, thereby resembling those of ordinary milk, except in size. There were no large globules, such as are usually met with in milk.

Besides the small globules there were a number of minute granules, and a few large cells filled with small oily particles (Plate VII. A, Fig. *a*, 2), something like colostrum corpuscles.

In consequence of a suggestion made in Nysten's *Medical Dictionary*, that the milky fluid from the tunica vaginalis might turn out to be merely a collection of escaped semen, spermatic filaments were carefully looked for; but none were detected, nor were any of the crystals usually encountered in seminal fluid to be found.

Ten days later, that is to say after the specimen was nearly a month old, it was somewhat changed in appearance: a curd equal to one-seventh of the total depth of the liquid had formed on the surface. This, although slightly yellower than the rest, scarcely deserves the name of a cream, being too pale and not sufficiently fatty to merit such a title. The liquid appeared to have become somewhat decomposed, for at the bottom of the vessel was a scanty deposit, the microscopical characters of which differed very materially from those already given. It consisted of some very large oil globules (Plate VII. A, Fig. *b*, 1) which had apparently formed by the coalescence of several of the small ones previously described. Besides which, amongst the fine granular matter were scattered several stellate crystals of margaric acid (Plate VII. A, Fig. *b*, 2). No cholesterine or other crystalline substance was at any period detected; nor at any time was a distinct cream observed on the liquid.

While making the foregoing observations, your reporters thought it advisable to ascertain, if possible, in what respect this lactescent liquid really differed from ordinary hydrocele fluid, and as a standard of comparison, the specimen of ordinary hydrocele fluid exhibited by Professor Fergusson to the Society along with the other was employed.

The appearance of the two liquids was, as already known, very different, the one being of a milky whiteness, the other of the ordinary translucent, pale amber hue. The reaction of the two was, however,

identical, so also was the odour; and both contained free sulphuretted hydrogen. The specific gravity was also nearly the same, the ordinary fluid being only two degrees lighter than the other. In fact, in all respects they appeared to resemble each other except one, namely, the absence of oleaginous matter in the ordinary fluid. As previously stated, by removing the fatty matter from the milky fluid, it assumed the appearance of the other. The counter experiment was also made, and by adding animal oil to the ordinary fluid it became of precisely the same appearance as the lactescent one. The natural conclusion therefore is, that the lactescent specimen is ordinary hydrocele fluid plus some of the fatty matters of the blood, probably exuded by the capillaries of the tunica vaginalis.

Finally, as regards the application of an appropriate name to the liquid. In order that the confusion likely to arise from a multiplicity of names may be avoided, your reporters venture to suggest that the term galactocele, although perhaps not the best that could be found, be applied to the present specimen, in consequence of M. Vidal having already given that title to the lactescent fluid from the tunica vaginalis described in his work. It is true that the analysis of the liquid, so ably reported by Vidal, differs in some respects from the present, but the difference consists merely in your reporters having detected, in addition to the other substances, phosphates, sulphates, and lime; a difference readily accounted for, however, seeing that a pathological and not a normal product is under consideration. They do not therefore consider themselves justified in giving to the liquid a new name, for the manufacture of new titles to already described pathological products, possessing certain well-marked characteristics, appears to them rather to retard than forward the progress of pathological knowledge.

Dr. George Harley,
Mr. Francis Mason, 17*th of January*, 1865.

---

21. *Diseased prostate gland.*

The subject of the specimen was a man æt. 54, who had been a patient under Mr. Mason's care at King's College Hospital. Five years ago he fell from a ladder, and got severely bruised, although he received no direct injury to the pelvis or urinary organs. From that time he had had occasionally some difficulty in micturition; and three years after he noticed that a little blood came with the urine. At the

date of his application, in August, 1864, he was suffering the most intense pain, and each attempt to pass urine was attended with the greatest agony. There was no family history of malignant disease. He remained under treatment for about three months—the remedies employed having little influence over the disease—and ultimately died exhausted. At the *post-mortem* examination, the body was found exhausted to the last degree. The prostate was extremely hard to the touch, and it cut like, and had to the naked eye the appearance of, scirrhus disease. The pelvic and lumbar glands were infiltrated with cancerous deposit, and in each inguinal region several similar hard nodules were observed. Dr. George Johnson had kindly examined the specimen with the microscope, and agreed with Mr. Mason as to the nature of the disease.

Mr. Henry Thompson, Dr. Murchison, and Mr. Mason were requested to make a further report on the specimen.

Mr. Francis Mason, *7th of February*, 1865.

Report on the above specimen.—The right lobe of the prostate is from two to three times as large as the left, which is of about the natural size. The naked-eye appearances do not indicate the existence of cancer. There is no tumour present; the healthy prostatic juice only issues on pressure after a freshly-made incision, and that in small quantity; there is no undue vascularity, and the structure is of uniform consistence throughout, and nowhere at all harder or firmer than in health. Making three fresh sections into the body of the prostate, and examining matter scraped from the surface, the following objects are seen under the microscope with a quarter of an inch power:—

1. Much granular matter.
2. Oil-globules in abundance, of all sizes.
3. Cells of various sizes, with several globules of oil in the interior, or attached; some with evident nuclei and nucleoli.
4. Cells adhering to each other (very common in the prostatic juice).
5. Small cells (size of pus-cells) filled with granules.

From these data, we infer that there has been no cancerous affection of the organ. It has probably been the subject of chronic inflammation, and of no other obvious change. The bladder itself has manifestly been for a considerable time in the condition of chronic cystitis.

Dr. Murchison.
Mr. Henry Thompson.

Appendix.—The reporters think it fair to add that, although the specimen does not, in their opinion, present the characters of cancerous tissue, it had been in a weak solution of spirit for nearly a month before it was referred to them for examination, and that, in its fresh state, Dr. George Johnson agreed with Mr. Mason in regarding it as cancer, from the naked eye as well as from the microscopic appearances.

Dr. Murchison.
Mr. Henry Thompson.
Mr. Francis Mason, *7th of March*, 1865.

---

22. *Congenital syphilitic disease of the testes.*

Dr. Wilks brought before the notice of the Society the case of a child, æt. five months, suffering from the ordinary symptoms of congenital syphilis, and in whom both testes were much enlarged. The left was larger than the right, and this was divided by a furrow into two equal parts, as if composed of the epididymis and the body of the testis. The case was not only interesting from its rarity, but as showing that the syphilitic disease of the testes is a true constitutional affection.

Three months after the date of the exhibition of the child, the testes had nearly returned to their normal size, and the other syphilitic symptoms had disappeared. The treatment had been mercurial inunction.

Dr. S. Wilks, *7th of February*, 1865.

---

23. *Malformation of penis.*

The child shown, æt. eight months, was fat, healthy, and in all respects but the penis, well developed. The pubic region was, perhaps, unusually large in relation to the body generally.

The penis, which was epispadic, had undergone torsion on its axis, so that the under surface presented upwards and to the left, and the child passed his urine towards, or even over, the left shoulder. The prepuce was ample, hung in a fold from the penis, and had the appearance of a scar terminating in a kind of pouch just below the glans, as though (adopting a suggestion of Dr. Harley's) the glans had, during fœtal life, passed through the side of the prepuce some third of an inch short of its orifice, which had been preternaturally closed. The crura penis could not be traced.

In *L' Union Médicale* for September 30th, 1862, to which my attention was directed by Mr. Holmes, a similar case is reported by M. Follin. The child was twelve years old, had complete epispadias, and the body of the penis was so twisted, that "sa face supérieure regardait en haut et à gauche." The frænum had a long prepuce attached to it.

Mr. Gay, 21*st of February*, 1865.

---

24. *Malignant disease of prostate.*

This case was brought before the Society as an instance of one of the rarer situations of malignant disease. It was that of a man, 70 years of age, who died in St. George's Hospital, under the care of Dr. Barclay.

For the last three or four years of his life, he had been unable to retain more than a small quantity of urine in his bladder, especially after taking alcohol in any form. About three months before his death he passed bloody urine, and continued to do so for about a fortnight; afterwards the urine was sometimes bloody, and sometimes apparently natural, but it was always voided in small quantities. He was about a fortnight in the Hospital, during which time, the symptoms were very vague, and not such as to lead to any suspicion of the nature of the disease. He had attacks of retching and vomiting; he had no appetite, and complained of want of sleep at night; he had no pain. The urine was quite clear and free from albumen. The tongue was clean; the pulse weak and feeble. He was not confined to his bed, nor even to his ward, and was thought not to have much the matter with him, until he suddenly began to sink, and died two days later.

At the *post-mortem* examination, there was evidence of chronic bronchitis, and traces of old tubercular deposit in the lungs. There was nothing else which needs especial mention, excepting what relates to the malignant growth. The prostate and base of the bladder were occupied by an encephaloid mass, over which the mucous membrane was stretched unbroken. The openings of the ureters were narrowed, so that a probe could not be got through them without a little pressure. The ureters were much dilated, as were also the pelves of the kidneys, which were atrophied by pressure, and adherent to the surrounding fat. Under the microscope, the mass in the prostate displayed a multitude of small cells, varying in shape, and sometimes nucleated. The tumour on pressure exuded abundant juice. A large mass of glands in the

DESCRIPTION OF PLATE VIII.

Illustrating Mr. Partridge's case of Transverse Hermaphroditism (p. 191).

The plate shows the relation of the parts as seen from the right side of the preparation.

a. Kidney.

b. Ureter.

c. Bladder.

d. Testicle in its tunica vaginalis, which, on this side, contained a congenital hernia.

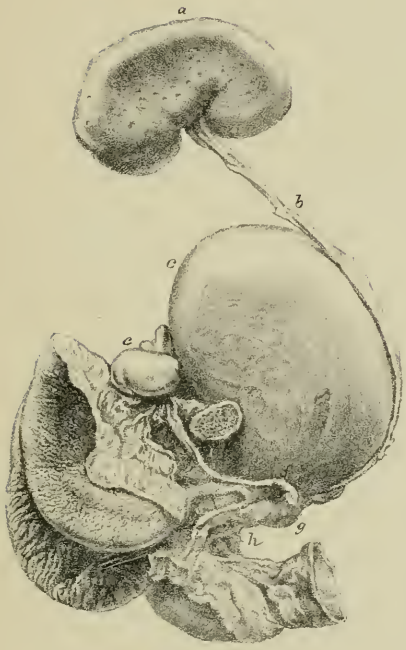
e. Vas deferens.

f. Prostate.

g. The greater labia.

h. Rectum.

i. Section of the os-pubis.



W. Bagg, del. et lith.

Hanhart, Imp.t

DESCRIPTION OF PLATE IX.

Illustrating Mr. Partridge's case of Transverse Hermaphroditism (p. 191).

The plate shows the relation of the parts as seen from the left side of the preparation.

a. Kidney.

b. Ureter.

c. Bladder.

d. Urethra.

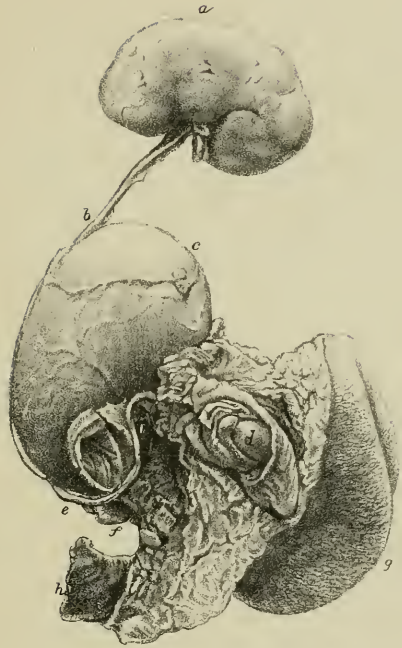
e. Testicle.

f. Vas deferens, terminating in the prostate.

g. Prostate, with an indication of vesiculæ seminales.

h. Tube, or pouch (probably the remains of the uro-genital sinus) situated beneath the urethra and extending from the prostate to between the labia, where it opens by a minute orifice below the meatus urinarius; a piece of bougie has been introduced into this pouch through its orifice, and its extremity is seen projecting between the labia.

i. Section of the os pubis.



W. Bagg del. et lith.

Hanhart, Imp.t

pelvis was infiltrated with a similar formation, and the aorta was completely embedded, for the length of six inches, among lumbar-glands in the same state. Dr. Dickinson, 21*st of February*, 1865.

25. *Transverse hermaphroditism.*

Mr. Partridge exhibited the genito-urinary organs of the child whom he brought for the Society's inspection on the 17th of November, 1863, and whose appearance is described at p. 154, vol. xv. of the Society's *Transactions*.

The child died when it had attained the age of five months, from an attack of pleurisy. At the *post-mortem* examination the urino-genital organs were removed entire, and afterwards carefully dissected: they are now preserved in the Museum of the College of Surgeons. The appearances observed in addition to those previously described are as follows:—The nymphæ, or what represents them, are *very much* smaller than in a female child of the same age; and it is important to remark that the small size of these parts may be taken as one indication by which the real sex of the individual may be determined, because in the *bonâ-fide* female infant the nymphæ are large, while in the apparent female (but real male) they are small.

Besides the orifice leading to the bladder, observed during life, another very minute aperture was discovered opening just below it, communicating with a tube or cavity situated beneath, and parallel to the urethra, but having no communication with it. This cavity, which appears to end in a *cul-de-sac*, is probably the remains of the uro-genital sinus. At the extremity of this sinus is a body resembling a prostate gland, in the upper part or base of which the two vasa deferentia, with some vaguely formed vesiculæ seminales, merge; whether they actually open into the prostate or into the uro-genital sinus could not, owing to the minuteness of the parts, be determined by dissection.

Both testicles, with their epididymes, are observable in the upper part of the (apparent) labia, and from each emerges a vas deferens, which descends into the pelvis in the usual manner, and terminates as already described. On the right side there is a congenital hernia.

The individual, then, is to be considered as an incomplete male, and an example of the so-called transverse hermaphroditism, which has been so rarely dissected and described in the human subject. (*See* Plates VIII. and IX.) Mr. Partridge, 21*st of March*, 1865.

26. *Gangrene of the entire penis, occurring with typhus fever.*

The patient was a labouring man, residing in Drury Lane, æt. 40, of temperate habits and healthy constitution.

On the 11th of July, 1857, he was attacked with typhus fever, became delirious, and remained unconscious for more than a week; at the end of that time it was observed that the penis had mortified. He had not been seen by any medical man until his admission into King's College Hospital, on the 27th of July, when the whole penis, as far as its root in front of the scrotum, was found to be gangrenous, with a distinct line of demarcation between the dead and living parts. The mortified part was black, half-dry, collapsed, and looked like the empty finger of an old black kid glove. The urine dribbled from an aperture between the gangrenous and sound parts.

In the course of a few days, the mortified penis dropped off, and the stump granulated and healed. By appropriate treatment, the man rapidly recovered his strength and health.

As the urethral orifice, after the cicatrization of the sore, seemed inclined to contract, it was slit up below, to the extent of the third of an inch, and the flaps stitched to the adjacent skin, by which proceeding a sufficiently large orifice was made and preserved. The preparation of the gangrenous penis, which was shown to the Society, is preserved in the Pathological Museum of King's College, London.

Dr. Murchison mentioned that he had met with several cases of mortification of the genitals accompanying typhus fever.

Mr. Partridge, 21*st of March*, 1865.

---

27. *The stump of a penis, after amputation, showing the good effects of slitting up the urethra in preventing subsequent contraction of its orifice.*

In this case the patient was a man past middle age, whose penis Mr. Partridge had amputated for cancer; at the same time he slit up the urethra along its lower wall, to the extent of the third of an inch from its extremity, and united the little flaps thus formed to the adjacent skin.

The result of this proceeding, which was first proposed and practised by the late Mr. Henry Earle of St. Bartholomew's Hospital, was that a good-sized urethral aperture was permanently formed, instead of the

troublesome contracted orifice produced by the transverse cut in this amputation.

The patient lived some time after the operation, dying at last of some internal disease. The specimen shown to the society, which is preserved in King's College Museum, shows a good-sized oval urethral orifice, the mucous membrane of which is smoothly continuous with the skin covering the end of the stump.

The man made water with perfect freedom, and in a full stream.

Mr. PARTRIDGE, 21*st of March*, 1865.

---

28. *Epispadias.*

The body of a man, æt. 22, having this malformation, was brought to the dissecting-rooms of King's College, from the Workhouse of the Holborn Union. The following is a description of the external appearances, and of the condition of the internal parts as ascertained by dissection.

The body, with the exception of the special malformation of the genitals, was well-formed, with a slight beard, and hair on the pubes and in the arm-pits. There was no unusual fulness of the breasts. The umbilicus occupied its natural situation. The scrotum was of the ordinary size, and rugous, but its raphé and that of the perineum were indistinctly marked. The right testicle hung lower than the left. The urethra, from the pubes to its distal extremity, was deficient at its upper part, presenting the appearance of a groove lined with mucous membrane, which was smoothly continuous on each side with the delicate skin of the penis, and at the pubes, by a good-sized orifice, with the bladder; this orifice was overhung and partly closed by skin and mucous membrane. The grooved urethra was furnished with lacunæ of the usual size and number.

The glans penis was bifid, or rather deeply notched from above. The penis was of its natural thickness, but rather shorter than usual. Dissection disclosed the following particulars:—The symphysis pubis was shallow and movable with an interval between the two ossa innominata, which were united by ligament instead of by fibro-cartilage, as in cases of congenital extroversion of the bladder.

The abdominal muscles, including the pyramidales, their tendons, and the abdominal rings and canals, were natural. The cremasters and the spermatic cords were of their natural structure.

Both testicles were in the scrotum, healthy and of their natural structure, though smaller than usual.

The vasa deferentia were of ordinary size, and had their usual course and termination. The vesiculæ seminales, ejaculatory ducts, and prostate gland, were normal in every respect. The urinary bladder was small.

There was nothing remarkable in the recto-vesical pouch, nor in the peritoneal folds in the site of the urachus, and of the epigastric vessels. The penis had two dorsal veins, which did not unite and pass under the symphysis pubis to terminate, as usual, in the prostatic veins, but which terminated one on each side, in the pudic vein.

The dorsal arteries and nerves presented nothing unusual.

The erectors of the penis were of their natural size and colour.

The crura of the penis were of their usual dimensions as to thickness, but rather shorter than ordinary. There was an indistinct broad layer of muscular fibres occupying the situation of the accelerator urinæ.

Injection of one corpus cavernosum distended that of the opposite side, but not so readily as usual; when both were fully distended with fluid, the glans remained flaccid, but it became distended when fluid was injected into the corpus spongiosum.

N.B.—The dissection of the parts just described is preserved in the Museum of the College of Surgeons.

I have been favoured by Mr. John Norton, of John Street, Bedford Row, Surgeon to the Holborn Union Workhouse, where this man resided for some time previous to his death, with the following particulars respecting him:—

"His urine constantly dribbled away when in the erect posture, but upon lying down it could be retained, and he seldom, if ever, 'wet his bed.' When walking, he threw his body back and extended his legs in a peculiar manner; this was no doubt owing to the mobility of the symphysis pubis. He was unable to do hard work, but was employed in the bakery of the workhouse, moulding bread.

"Nothing could be ascertained as to his sexual propensities and powers."

Two preparations of epispadias are contained in the London Museums; one in that of the London Hospital of a case mentioned by Mr. John Adams, in his article, "Urethra," in Todd's *Cyclopædia of Anatomy and Physiology*. Mr. Adams, in a note to me, says, "The patient was an adult male, admitted for an accident into the London Hospital, and the malformation was not discovered until after

his death. He was married, but nothing further was known of him."

The other preparation, in the Museum of St. Bartholomew's Hospital, is described in the catalogue as " from an adult. A median cleft along the back of the penis extends into the urethra, from its orifice to the pubes. A loose fold of skin covers the fissure in its whole extent. The penis is short, but the other parts are well-formed."

Mr. PARTRIDGE, *2nd of May*, 1865.

C.—FEMALE GENITAL ORGANS.

29. *Ovariotomy, fatal by diffuse peritonitis.*

Mr. Holmes exhibited a multilocular ovarian tumour, which he had removed by ovariotomy, at St. George's Hospital, on July 7th, 1864. He remarked that his chief object in exhibiting the preparation was to place on public record the occurrence of an unsuccessful case, since there was an impression in some people's minds that such cases are systematically concealed. This impression he believed to be quite unfounded as far as relates to the practice of surgeons at the present time.

The patient, an unmarried woman, æt. 29, was admitted into St. George's Hospital in May, having been sent from the country in order to have the operation performed. The tumour had been growing for eleven months, with great emaciation and distress, but no distinct evidence of any special disease. She was tapped, and two gallons of glutinous fluid were drawn off. This gave temporary relief, but the tumour filled again very rapidly. It was almost immovable, and was firmly wedged in between the uterus and rectum, so that some difficulty was anticipated in its removal, as it was judged to be extensively adherent. This was found to be the case, but the adhesions did not oppose such an obstacle to the removal of the tumour as was expected, since, though very extensive, they were soft and separable by the hand without force or hæmorrhage.

She went on well for about forty-eight hours, when sudden pain came on in the right iliac region, and she sank rapidly. At the *post-mortem* examination the wound appeared, at first sight, to be united; but on closer inspection it was found to be merely in accurate apposition, without any uniting material. There was a good deal of bloody fluid

in the pelvis, which had doubtless oozed from the torn adhesions. The remains of these adhesions were visible in roughness and small ecchymoses on the liver, the lumbar and pelvic peritoneum, and various parts of the abdominal wall. The intestines were coated with a thin film of purulent matter, and were much congested. There were a few crude tubercles in the apex of the left lung, and the liver was fatty. Otherwise the viscera were healthy. The pedicle had been secured outside the abdomen, at a distance of about an inch from the uterus, without any apparent traction on that organ.

Mr. Holmes, 1*st of November*, 1864.

---

30. *Cancer of the ovaries, producing fatal obstruction of the bowels. Cancerous nodules of the peritoneum.*

A woman, æt 49, was admitted into the physicians' wards of the Westminster Hospital, on the 14th of October, 1864, with the abdomen enormously distended and tympanitic, having been suffering from constipation fourteen days. Purgatives were administered without effect, and enemata were also employed. The long tube was then passed as high as possible until an obstruction was met with, and the tube being left in, a large quantity of flatus escaped by it, the abdomen becoming much less tense. On introducing the finger into the rectum, a tumour was discovered pressing upon the bowel and occluding it; the tube could be passed beyond this tumour, but was again arrested about two inches higher up. *Per vaginam*, the uterus was found to be fixed in the pelvis, but the os and cervix were perfectly healthy. On the 19th of October a consultation was held upon the case, when it was resolved that Amussat's operation should be performed on the following day, but the patient unfortunately sank during the night, the constipation having lasted twenty days.

On *post-mortem* examination, the abdomen was found to be enormously distended, the intestines being filled with liquid fæces. The whole of the peritoneum was found to be studded over with cancerous nodules of various sizes, but averaging the size of a pea. The true pelvis was filled with a mass of disease, which upon removal and careful dissection showed the following conditions :—The right ovary was converted into a mass of soft cancer, of the size of a small orange, and was closely attached to the fundus of the uterus, which was healthy, but pushed over to the left side. The left ovary was in much the same condition, but of smaller size. The

rectum was enormously distended in its upper part, but empty below, and the obstruction was found to depend upon adhesions which formed between the back of the right ovary, the uterus, and the rectum, by which the bowel had become bent in a sharp sigmoid form, and bound down so firmly that it was impossible for fæcal matter to pass. A catheter could be passed through the twisted rectum with care, although at one point the calibre appeared to be diminished by deposit in its walls, which, however, proved not to be the case when the bowel was laid open. The bladder and ureters were uninvolved in the disease, and the liver and kidneys were healthy. The thoracic organs were quite healthy. Mr. Christopher Heath, *1st of November*, 1865.

---

31. *Case of tubular fœtation.*

This specimen was taken from the body of a female who died in King's College Hospital, but whom Dr. Playfair had not seen during life. She was admitted on account of excessive and incessant vomiting, which had lasted for upwards of six weeks, and had resisted all treatment. She also complained of severe pain in the abdomen, principally referred to the epigastric region. For a year previous to her admission she had suffered much from dyspepsia, and was said to have vomited blood on two separate occasions. She had not menstruated for four months, but she had long been very irregular in this respect, and did not herself suspect the existence of pregnancy. A diagnosis of gastric ulcer was made, and when, on the tenth day after she was received into the Hospital, sudden collapse came on, it was supposed that perforation of the stomach had taken place.

On *post-mortem* examination, a large quantity of blood was found in the peritoneum, and in the right Fallopian tube was a fœtus apparently at the fourth month of gestation. The cyst was about the size of an orange, and consisted of the distended Fallopian tube. The placenta was formed, and attached to the interior of the cyst. The perforation which had caused the collapse was on the posterior surface of the distended tube, and was not larger than a three-penny piece. No blood had been extravasated into the cyst itself, the relations of which to the contained fœtus were therefore unusually well seen. The corpus luteum was situated in the right ovary, and the uterus was large, and contained

an imperfect decidual membrane. The stomach and abdominal viscera generally were healthy.

Dr. W. S. Playfair, *7th of February*, 1865.

---

32. *Malignant disease of uterus, involving the whole of its internal surface, except the inferior portion of the canal of the cervix. Secondary deposits in both lungs.*

S. B., æt. 39, single, admitted into St. Bartholomew's Hospital, under Dr. Greenhalgh, October 24th, 1864.

History.—Had good health up to two years and a-half ago, when she caught cold, and had severe flooding for five or six weeks. Recovered perfectly in about four months' time, and remained well up to June, 1864, when, after an attack of rheumatism, her abdomen began to enlarge, at first in the right iliac region. This swelling soon occupied the whole abdomen, and was supposed to be ovarian, but on careful examination was ascertained to be a uterine tumour, probably fibroid. On October 1st, a sound, passed with some difficulty through the os uteri for five inches and a-half, gave exit to about a pint of claret-coloured, very offensive fluid. Severe rigors followed the operation. Up to this period her health had not materially suffered.

On admission, on the 24th of October, the abdomen was very prominent, bulging outwards greatly on the left, less so on the right side; umbilicus somewhat receding. A pyriform swelling, regular in outline, firm, and somewhat elastic, dull, not fluctuating, slightly movable laterally, and not tender, extended from the pubes to midway between the umbilicus and ensiform cartilage. *Per vaginam*—the vagina much elongated. The os uteri irregular in shape and small. The cervix firm, somewhat enlarged, movable over the finger by firm pressure on the abdominal swelling. The sound passed with difficulty and pain, but in the normal direction, for five inches and a-half; this was followed by the escape of a claret-coloured, very offensive liquid. During her stay in the Hospital, great relief was given by enlarging the canal of the cervix with the metrotome, thus favouring the exit of the fluid; several polypoid masses also came away, partly coagula, partly growths, which under the microscope were found to be cellular, and to present characters resembling those of epithelial cancer. On December 21st,

twenty-four to twenty-six ounces of a claret-coloured, self-coagulable fluid was removed by puncturing the tumour with a grooved needle about half-an-inch below the umbilicus. In spite of an attack of pneumonia of the left lung, she left the Hospital shortly after Christmas, improved in her general health, and with the tumour reduced in size. On February 4th, 1865, she was readmitted in a state of great prostration, and died in a few hours.

Post-mortem examination, thirty-six hours after death.—Recent peritonitis; the effused fluid purulent, but not blood-stained. The uterus enormously enlarged, rising nearly to the ensiform cartilage; its external surface smooth and regular, except that on the sides are one or two cysts projecting slightly above the general level. On opening it, two pints of offensive fluid escape, and the cavity is found to be occupied by a fetid sloughing mass springing from the whole of the internal surface, except the lowest inch of the cervical canal. This growth is in the form of large long processes springing from an uneven base, is infiltrated with blood, and numerous coagula are entangled in it. Under the microscope, the processes are found to consist principally of cell-like bodies of very various and irregular outline, containing numerous opaque granules, and the greater part of them, nuclei. Their size varies from that of a red blood corpuscle to three or four times that size. Here and there are round or oval capsules, containing large numbers of these cells. Scattered throughout both lungs are numerous deposits presenting similar microscopical characters. No alteration was detected in any lymphatic glands. Dr. J. Andrew, *7th of February*, 1865.

---

33. *Large ovarian cyst closely adherent to the uterus, in wh ch were developed three large fibrous tumours.*

Emily W., æt. 40, was admitted into University College Hospital, under my care, on January 3rd of this year. Had been married more than twenty years, but had had no children; stated that she had had three miscarriages during the last six years, but the certainty of these miscarriages was very doubtful.

In April of 1864 she had first noticed a tumour in the lower part of abdomen; it caused some pain, but was only about the size of a walnut. At the latter end of May she began to vomit, at first once or twice a day, but afterwards she vomited as often as seven or eight times in twenty-

four hours. During the fifteen weeks before admission she had had more pain in abdomen of a bearing down and heavy character, and when she walked the tumour pressed down on the bladder, and caused incontinence of urine. One of the "miscarriages" before mentioned occurred in the first week of September, 1864; at any rate, she had then a violent flooding.

On her admission, a considerable mass was felt in the lower part of the abdomen, and this mass was exceedingly tender on pressure; her decubitus was on the back, with a slight inclination to the left side; she still vomited several times a day; the abdomen was not distended, but, on the contrary, fairly flaccid, so that had it not been for the great tenderness the examination of the tumour would have been very easy. On a further examination a few days subsequently, the abdominal tumour, which had meanwhile become a little more prominent, formed a considerable projection in the hypogastrium, and was situated rather more to the left than to the right of the median line; it appeared to be of about the size of a small child's head, the most prominent part being at two inches and a-half above the os pubis, and one inch to the left of the median line. The mass reached to within one inch and a-half of anterior superior spinous process of left ileum; upwards, it extended to within one inch and a-half of umbilicus. A portion of the circumference was covered with intestine which, as the diaphragm ascended and descended, moved freely over the borders of the mass; but the tumour itself was uninfluenced by the movements of the diaphragm. The general shape of the tumour was very globular; it was smooth on the surface, was very slightly movable, and it extended deeply behind the os pubis; to palpation it was hard, but by no means entirely unyielding. Over its most prominent part there was a slight amount of fluctuation, but owing to the pain caused by the examination, it was uncertain whether fluctuation extended throughout the whole mass.

On a vaginal (digital) examination being made—it was made as briefly as possible in consequence of the pain caused by the finger, especially at the upper left side of the fundus of the vagina—the following conditions were found:—The upper end of the vagina terminated in a hardish circular mass, convex downwards; it was not equally hard all over, as its left half, at least, had a distinctly elastic (though *tense*) feel, and presented, I thought, some degree of fluctuation. From the middle of the mass projected downwards what I recognized as the cervix uteri, but it inclined from above downwards and to the left.

To the right of this there was, firmly adherent to the general convex mass terminating the vagina, a body of about the volume of a middle-sized fig, and of a pyriform shape; the thicker end was distal to the above-named cervix uteri, but the smaller end seemed to be continuous with it, and therefore the mass was probably the uterus, or a portion of it, detruded downwards and to the right by the general convex mass. This general convex mass seemed to be a part of, or connected with, the fluctuating tumour detected above the os pubis, but no fluctuation could be distinguished as passing from the fundus of the vagina to the part above the os pubis; a thorough examination, however, could not be made owing to the pain which the attempt produced. The general convex mass seemed to fill up the upper part at least of the pelvis almost completely, and to be very immobile.

The diagnosis I gave was that the general convex mass was probably a portion of the same tumour which was felt to fluctuate above the os pubis; that it was probably an ovarian tumour containing fluid, but very thoroughly adherent to the left side of the body of the uterus, which organ the ovarian tumour had much detruded to the right; that, as there had been uterine hæmorrhage three times, there was probably also uterine disease; but that there was no proof of this disease being of a cancerous character.

The temperature of the body, at first scarcely elevated, became high, and her pulse rose to 120, but the respirations sank to 7, 6, and even 5, per minute. There was great pain with tenderness of the abdomen, and these symptoms were very little, if at all, relieved by some leeches and poultices applied. She gradually got weaker, and died on the 14th of January.

Post-mortem examination.—The lower part of the abdomen was occupied by a globular mass, about the size of a large child's head, which reached up to four inches and a half above the os pubis. Surrounded by intestine on all sides except the lower, an area of about two inches and a-half square was alone in contact with the parietes. On the left side there were some old adhesions to the sigmoid flexure, and to the middle of its anterior part a band-like portion of omentum was firmly attached. The tumour itself was exceedingly immobile.

The tumour and the bladder, with a portion of the vagina, were removed together. The uterus was longer than natural, and its fundus was inclined a good deal to the right side; in the right half of its body was developed a mass of the size and shape of a small orange, which on

being cut into was found to be of almost cartilaginous hardness near its circumference, while all the rest of it was of no more than the consistence of putty. From the posterior part of the fundus of the uterus a peduncle of apparently uterine substance projected, and was united at its extremity to a well-marked fibrous tumour, of about the size of the one just described; this one was of almost cartilaginous hardness throughout, but there were two or three small cavities in it which might equal in size a split pea or so. The right Fallopian tube and ovary presented nothing remarkable, except that the former was much harder than natural about its insertion into the uterus, and there was at that point, embedded in the uterus, and so placed as apparently entirely to block up the aperture of the tube, a tumour of the size of a small filbert.

Closely adherent to the left half of the uterus was a large cyst, the one already described as being of the size of a child's head. So intimately united was this to the uterus that, until careful dissection proved the contrary, the cyst seemed to be a part of, or to arise from, that viscus itself. Its contents were twenty-eight ounces of a puriform fluid, and when the whole was removed, and the cyst itself washed, the interior of the sac presented a distinct lining membrane, at first sight not unlike that of the bladder; it was marked with a number of little pits varying in depth and size, and it exhibited here and there some trabeculæ, which were, however, but slightly elevated. Along the upper and posterior part of this cyst there ran a slightly elevated ridge, about the breadth of a finger, and five or six inches in length; this, on being cut into, was found to be a canal which at its end distal to the uterus communicated, by a jagged opening, with the cavity of the cyst. The canal was evidently the left Fallopian tube greatly dilated and altered. No left ovary existed, but it was represented by the large cyst which had been developed out of it.

Remarks.—The nature of the three harder tumours, two of which were situated in the substance of the uterus, and the other of which was attached to the organ by a peduncle, was unmistakeable; they were fibrous masses, of which one had undergone a marked and extensive degree of softening. But the character of the cyst was at first very doubtful, for the question naturally arose as to whether this body was an ovarian cyst or a fibrous tumour which had undergone a further amount of the same kind of softening as that presented by

one of the other masses; for in this latter mass the softening was such in the interior, compared with what existed at its outer part, that it would have required but little more softening to have rendered it fluid. There were, however, several circumstances which ultimately left no doubt as to the fact of the large cyst having been originally the left ovary. 1. No other remains of the left ovary could be found. 2. The altered and distended Fallopian tube was intimately connected with it; and the jagged opening by which the tube communicated with the cyst was doubtless the fimbriated extremity of the tube, which had become adherent to the ovary or cyst as it enlarged. 3. The walls of the cyst were too exactly *uniform in thickness* to render it probable that they would have been left so by the gradual softening of a solid tumour. 4. No masses of partially softened fibrin were found in the fluid of the cyst; this fluid (which also filled up the dilated Fallopian tube) had a uniform creamy or puriform appearance, but under the microscope it presented few, if any, true pus cells; there was a large amount of granular matter and of fat, and there were some cells smaller than those of pus, and having in their interior granular matter rather than the nuclei of pus cells. 5. By careful dissection the cyst could be detached from the body of the uterus, except at that part where the left Fallopian tube would have been united to it.

One of the interesting pathological points in this case, then, was the coexistence of a large ovarian tumour with well-marked fibrous tumours of the uterus, and the importance of this coexistence in connection with operative procedures for the removal of ovarian cysts is obvious, though the coexistence of the two conditions to the degree which was present in this case is rare. In connection with ovariotomy, also, the case is interesting, inasmuch as the facts noted during life were sufficient to lead to the diagnosis that the tumour, though closely adherent to the uterus, was ovarian, but that there also coexisted disease of the uterus itself. Dr. HARE, *7th of March*, 1865.

---

34. *Rupture of uterus in an early period of pregnancy.*

This case was involved in obscurity, at least so far as the cause of the laceration was in question.

In March, Dr. Dickinson was requested to assist at the *post-mortem* examination of a young unmarried lady. The body was that of a woman æt. 25, who had been dead somewhat less than twenty-four

hours. The features and whole body were changed by decay, notwithstanding which, traces of personal beauty remained. There was much green and brown discoloration; there were large vesications in many places, particularly upon the upper parts of the thighs, and the skin was raised up by foul gas, which escaped in puffs through the incisions. There were dark areolæ round the nipples. Allowing for the effects of the rapid decomposition which had taken place, all the organs were natural, excepting those of generation. The blood was perfectly fluid. The left ventricle of the heart was quite uncontracted. The brain was softened and discoloured by *post-mortem* changes, and was full of small, round cavities containing gas, so that it bore a great resemblance to Gruyère cheese.

A little blood lay in the pelvic part of the peritoneal cavity; the uterus, as it appeared *in situ*, was larger than in the unimpregnated state, and upon its front was a large irregular patch where the peritoneum seemed wanting. When taken out, it was found that this appearance was caused by a large irregular rent which occupied about half the anterior aspect of the organ, reaching up to the fundus. This had been filled by a clot of blood, which fell out when the organ was removed. The rent was very irregular, and was more extensive on the peritoneal surface than towards the interior. The uterus was of such a size as might have belonged to the third month of pregnancy. The cavity was partly open, and contained bloody fluid; the os was wide enough to admit a finger, and the vagina was somewhat dilated. No trace of an ovum could be found in the uterus, vagina, or peritoneal cavity. The interior of the uterus was roughened, especially on a patch on its upper and posterior part, to which a placenta might have been attached. A corpus luteum existed in the ovary. The muscular fibre of the uterus was stained red by the fluid and decomposing blood, and when examined with the microscope was found to retain few traces of its natural structure.

The circumstances which attended the death of this young lady were, as far as could be learned, as follow:—

It appeared that she knew that she was pregnant, and that measures had been taken for her subsequent confinement. She was seen by a medical man a week before her death, and then appeared much in her usual health. On the day of her death she saw this gentleman again, who was not aware of her condition, and told him that she had been unwell in January, and that at the present time she was again unwell and was suffering from having taken cold in this condition. She then

had a considerable discharge of blood from the vagina, and complained of much pain about the pelvic organs. A simple aperient pill was prescribed, and was administered by a female servant. After this she appears to have been left alone for about an hour and a-half, and when seen at the end of that time she was dead. Dr. W., in the immediate neighbourhood, who had not seen her before, was at once sent for, and he found the body propped in bed in an upright position, with the right arm rigidly flexed across the belly. The face was livid. There was a towel as a binder round the abdomen, and there was evidence of a considerable loss of blood from the vagina.

A coroner's inquest held subsequently was hastily conducted, and threw no further light on the matter.

Remarks.—There are cases on record of "spontaneous rupture" of the gravid uterus at as early a period of pregnancy as two months and a-half. I may instance one case, quoted by Dr. Trask in the *American Journal of Medical Science* for January, 1848. A young woman, in the middle of the third month of her fifth pregnancy, felt a cracking in the abdomen while waltzing after dinner, became collapsed, had pain and swelling of the belly, and died thirty hours afterwards. A rent two inches in diameter was subsequently found in the upper part of the uterus; and the ovum, besides much blood, was found in the peritoneum. It was supposed in this case that the uterine tissue, though generally natural, had been softened in the neighbourhood of the rent. Other cases have been recorded somewhat similar in character. How far these rare cases are to be looked upon as of the same character as the case before the Society is a matter of doubt. Owing to the rapid decomposition which had taken place, the microscopic characters of the uterine tissue were obscured, and if any morbid changes had taken place which could lead to the rupture, it was no longer evident. The fact that the ovum was not to be found in the peritoneal cavity seems to suggest that it had been removed by external interference, since it is scarcely possible to suppose that the uterus, torn as it was, could have expelled it by its own action; and the very rapid death of the patient also gives probability to the view that some violence had been used to account for the more rapidly fatal collapse than has been recorded in cases of spontaneous rupture. Besides these considerations, the illicit origin of the pregnancy is another ground for suspicion. But on the other side may be urged that, as was stated, this young lady was seen in tolerable health by a respectable servant an hour and a-half before she

was found to be dead, and that she had not been since visited by any person. If these statements are trustworthy, it follows that, if violence was used, it must have been by her own hands. Dr. Graily Hewitt, who kindly examined the preparation, was of opinion that the rupture was the result of violence, and that a blunt instrument, possibly the finger, had been the means employed. It seems, however, difficult to believe that a woman could in such a manner produce so severe an injury, since it must necessarily have caused acute pain, and was so high up as to be, as we should suppose, quite out of reach of manual violence.

It is probable that the mystery which envelopes this case will never be cleared up. Dr. Dickinson, *4th of April*, 1865.

---

35. *Semi-solid ovarian tumour.*

This tumour weighed thirty-seven pounds after four pounds of fluid had drained out of it. It was removed entire the day before the meeting, from a woman, 30 years of age, in the Samaritan Hospital. It was non-adherent, but as it contained no large cysts, a long incision was required—the longest Mr. Wells had ever made. It extended twenty inches in the distended integument, but when united and the skin had contracted it only measured thirteen inches. The patient rallied well at first, but sank exhausted twenty-seven hours after the operation. The tumour consisted of an immense number of very small cysts, many of them being filled with fibrin in different stages of fatty change. The operation would have been done some months earlier, but the patient then suffered from effusion into the left pleura and also into the peritoneal cavity. The ascitic fluid was twice removed by tapping, the pleural fluid was absorbed, the general health improved, and then the operation was done, though with very little hope of success, on account of the still weakly state of the patient and the large size of the solid tumour.

The tumour was carefully examined after the meeting by Dr. Harley, of University College, and by Dr. Ritchie, who reported it to be "an immense ovarian tumour, characterized by the number and comparative minuteness of its loculi and by the diversity of their contents. No two loculi agreed in size, or in the kind of contained fluid. The largest loculi were no larger than two closed fists, and were not near the surface of the tumour, but, on the contrary, deep in

its substance. Very few of the cysts contained clear serum; several were filled with gruelly ovarian fluid; but the great majority of them contained a fluid in which were suspended flakes of fibrin in various stages of fatty degeneration. The lining membrane of some of the smaller cysts was puckered in folds. Many cysts were flattened in such a way that they could contain little or no fluid, and their agglomeration gave a solid consistence to that part of the tumour where they abounded." Mr. Spencer Wells, *4th of April*, 1865.

---

36. *Ovarian tumour successfully removed.*

Mr. Holmes exhibited a multilocular cystic tumour of the ovary of very large size, which had been successfully removed at St. George's Hospital by Mr. Tatum. The history of the case need not be given in detail. The patient was 25 years of age, unmarried, and in good general health. The disease had been noticed less than two years. She had been tapped more than a dozen times, the quantity withdrawn varying from four to eight gallons. The fluid was at first perfectly clear and limpid, and contained a very small quantity of albumen, but gradually got thicker and more albuminous. The abdomen always rapidly filled again, and of late, especially after the last tapping, there were distinct symptoms of peritoneal inflammation. The tumour consisted in the main of one large cyst, as was proved by the readiness with which fluctuation was communicated from any one part of the abdomen to any other, when it was distended; but there were also some others, for on examination after tapping, a soft, movable, lobulated swelling, like a bunch of small cysts, could be felt on the right side of the abdomen, and this appeared to be fixed in its position.

The patient obtained no permanent relief from paracentesis, and in fact hardly any temporary relief, for the tumour would regain its former size in about six weeks. The symptoms of peritonitis also, and the redness round the puncture, showed that tapping would not be borne with impunity much longer. She was recommended, therefore, to submit to the operation of excision, which was accordingly performed on the 27th of March, 1865, in one of the Hospital wards. The ward had previously been well heated and the air moistened with steam. The incision, which lay entirely below the umbilicus, was between six and seven inches in length, but after her recovery measured probably less than three inches. The large cyst was so firmly adherent to the an-

terior wall of the abdomen that it was necessary to divide many of the adhesions with the knife. This being done, there were no further obstacles to the delivery of the tumour. The pedicle was short and funnel-shaped. It was transfixed with a stout silver wire, which was then firmly twisted on each side, and the tumour separated. The pedicle and silver ligature were then dropped back into the pelvis.* None of the abdominal viscera were seen during the operation, except a small portion of the small intestine, which was congested. The other ovary was ascertained to be healthy. The wound was brought together with six silk sutures, the peritoneum being avoided.

Recovery ensued with no drawback, the only unfavourable symptom being pain from flatulent distension of the bowels and constipation during the first few days after the operation. At the time of exhibition of the specimen she was quite well, and on the point of leaving the Hospital. No indication of the position of the pedicle could be discovered, either by vaginal or external examination.

Mr. Holmes, *2nd of May*, 1865.

---

37. *A specimen of an inverted uterus which during life had been successfully removed by ligature.*

The specimen was of the size of a "small apple," having a rough, shaggy, external surface, and a cup-shaped cavity in which the Fallopian tubes were visible. The specimen was presented to St. George's Hospital by the late Mr. Stone, and had been originally removed by the late Sir C. Clarke. The case is related by Dr. Gooch, and appears in Dr. Fergusson's edition† of *Gooch on some of the more Important Diseases peculiar to Women*, &c., p. 131. Speaking of polypus of the uterus, Dr. Gooch observes :—"Inverted uterus, being a rare occurrence, is less likely to be met with; but when it is, it is more likely to be mistaken for polypus. When the uterus is only partly inverted, that is, when its fundus only is drawn down through its orifice into the vagina, and the patient has survived for many months, the tumour feels exactly like a polypus of the fundus. The distinguishing marks are, the time of its first appearance, which must have been immediately after delivery, and its sensibility. In the smoothness of the sur-

* This method of securing the pedicle in ovariotomy was claimed by Dr. Marion Sims at the meeting of the Society as his invention.

† New Sydenham Society's Edition.

face, the roundness of its body, the narrowness of its neck, and its being completely encircled by the orifice of the uterus, it sometimes exactly resembles polypus of the fundus." Dr. Gooch then proceeds to detail the history of a case which is the one to which the specimen now shown to the Society pertains. He observes, "The first time I saw the patient was in consultation with Dr. Clarke and Dr. Henry Davies. She had been delivered some months before at St. Omer, and immediately after the removal of the placenta, which had been extracted with some violence, a tumour had been felt projecting from the uterus into the vagina, since which she had not only had no hæmorrhages, but had not had even ordinary menstruation. When we examined the tumour, we found it about the size of a small apple, with a smooth surface, and a somewhat narrow stalk, which was completely encircled by the orifice of the uterus. It was exactly like a polypus, but its quick sensibility to touch, and the circumstances under which it made its first appearance, inclined us to believe that it was an inverted uterus and not to recommend its removal, particularly as she was losing no blood, and her health was sustaining no injury from it. She returned to the continent, and I did not see her again for two years, when she again came to London to place herself under the care of Dr. Granville, who had recommended her to submit to an attempt to revert it, and I now saw her in consultation with the doctor. Since my former interview with her she had become subject to frequent and profuse hæmorrhages, which had bleached her face and broken her health, and it now became an urgent object to afford her relief even at some risk. We agreed, therefore, that the attempt should be made to revert the tumour; but if this failed, which appeared most likely, we proposed to her husband the removal of the tumour by the ligature, stating to him that such an operation had been done successfully, but that it was attended with considerable risk. This both he and the patient were willing to incur. The attempt at reduction failed; but before applying the ligature, her former attendants, Dr. Clarke and Dr. Henry Davies, were consulted, and all of us agreeing to recommend the operation, the ligature was applied by Dr. Clarke; it was tightened every other day, and each time occasioned so much pain as to require a large opiate to quiet it. At length, on the fourteenth day, both instrument and tumour came away. There were times when I had a strong suspicion that it was a polypus, but a sight of the tumour proved that it was the fundus of the uterus, for it was a hollow cup the size of a small apple, in the cavity of which could be seen the Fal-

lopian tubes. Excepting the pain and some vomiting, the patient had no bad symptoms during the progress of the cure, and several months afterwards her husband called upon me to say she was quite well."

Such is the description and history of the specimen as given by Dr. Gooch. It was brought forward for the notice of the Society, with the intention that comparison might be established between it and the following specimen, which appeared to Dr. Ogle to be of a doubtful character, in order that by examination of it the members might be assisted in coming to a conclusion regarding the latter.

Protrusion of a large mass from the vagina supposed to be an inverted uterus; successful removal by the écraseur.

This specimen had been sent by Dr. Slayter, of Halifax, in Nova Scotia, and placed in Dr. Ogle's hands by Dr. G. Milroy. The details of the case are described as follows by Dr. Slayter.

"On Tuesday, the 25th day of February, I was called to see a Mrs. Glazebrook, who, at the time, was reported to be in labour. On examination I found a tumour presenting and external to the vagina. The tumour appeared to be solid and about the size of a seven or eight months' child; it was attached to the vagina by a neck fully six inches in circumference. The surface was of an ash or slate colour, and peeled off in patches, below presenting a congested, red appearance. On making an examination *per vaginam*, I found the neck extended upwards five or six inches, forming a *cul de sac* anteriorly and exteriorly with ligamentous bands laterally. At the junction of the neck with the tumour there was considerable swelling and congestion, and from the vagina oozed a small quantity of blood; a strong fetid smell was emitted from the parts, and the woman appeared nervous and suffering from constitutional irritation. As the neck of the tumour was continuous with the vagina, and no appearance of an 'os,' I came to the conclusion that the uterus was inverted and very much hypertrophied. On inquiry, I found that the woman was 33 years of age, and mother of six children. About eight months previously she had a miscarriage—a fœtus (seven months) was expelled while she was in the upright position, the result of a strain from lifting a heavy weight. She recovered rapidly, and did not notice anything unusual at the time. A few months afterwards she thought herself again *enceinte*, her stomach became gradually enlarged, as was customary in previous instances, and she actually fancied she felt motion; but she menstruated every month, which was unusual with her. Three weeks previous to the 28th of

February she jumped a distance of three feet, and felt a clot of blood pass away; this was followed by pains of a breaking-down character, increasing until the expulsion of the tumour took place. On inquiry, I found that several days before the mass was expelled from the vagina there was a disagreeable odour emitted from her.

"The urethra was retracted fully an inch, and the curve was so sharp as to render it an impossibility to pass the catheter half an inch. The surface of the tumour becoming very gangrenous, I removed it with the écraseur. There were not two ounces of blood lost during the operation, the parts easily retracted, and the urethra returned to its natural position. The woman made a very good recovery, and is now walking about apparently as well as ever."

The specimen, as shown to the Society, consisted of a large, firm, dark-coloured solid mass, with a shreddy surface at its lowest part, having no cavity in its interior, and showing no Fallopian tube in connection with it, but having at its upper part a slight cup-like depression, lined by a smooth membrane, around which could be seen a roughened surface occasioned by the use of the écraseur. The whole mass was of the size of a largish cocoa-nut. On examination, Dr. Ogle was led to think it was not to be considered merely a specimen of inverted uterus, but a fibrous tumour connected with an inverted uterus, a small portion of which alone had been removed, and he supposed that the smooth cup-like depression on the summit of the preparation was, in fact, a portion of the serous or peritoneal surface of the uterus, which had been drawn inwards, and included within the écraseur.

A committee, consisting of Dr. Marion Sims, Dr. Graily Hewitt, and Dr. Ogle, were appointed to report upon this specimen.

Report on the above Specimen.—The mass consists for the most part of a large fibroid tumour of the uterus which has assumed a polypoid form; but it includes, further, that portion of the uterus itself to which the polypus was attached. It measures four inches and a-half in diameter, and two inches and a-half in thickness. The general shape is that of a melon. On one aspect of the mass is a surface one inch long, of an ovoïd shape, slightly depressed in the centre, and having a perfectly smooth appearance. This, which is evidently the peritoneal surface of the uterus itself, is surrounded by a ring half an inch broad, marking the line of separation by the écraseur. Section of the tumour shows very distinctly that the portion cut through by the écraseur is

true uterine tissue, with which the polypoid mass is firmly and inseparably connected.

There can be no doubt that the case was one of polypus of the uterus, growing, probably centrally, from the interior of the organ, and giving rise to partial inversion of the uterus. In separating the tumour the écraseur was made to cut away that portion of the uterus which was most dependent, and which doubtless at that time formed a part of the pedicle of the tumour. The portion of uterus removed is in all probability the whole of that portion of the fundus intervening between the origin of the Fallopian tubes.

Dr. John W. Ogle,
Dr. J. Marion Sims,
Dr. Graily Hewitt, *June*, 1865.

VI.—DISEASES, ETC., OF THE OSSEOUS SYSTEM.

1. *Necrosis of turbinated bones and part of the vomer treated by aid of the rhinoscope.*

A gentleman, æt. 45, consulted me in May, 1864, for an affection of the nose. A slough, the size of an ordinary oyster, had come away once a fortnight for some weeks past from the posterior nares, and three or four had thus been observed. The odour was most intolerable. The uvula was quite destroyed, giving to the soft palate an arched appearance, all the result of a specific influence. The speech was thick, and the laryngoscope revealed complete pendency of the epiglottis, but no disease of the larynx. The rhinoscope (very easily applied) showed numerous large ulcers on the posterior surface of the velum palati, with bright red margins and purulent surfaces, running into the floor of both nostrils posteriorly. The left nostril in front was seen to be ulcerated on the septum. Ozœna had been present since Christmas. Under local and general treatment he improved. Subsequently a slough was seen at the base of the septum with the rhinoscope, which came away; others passed until the 21st of July, when a large one, the size of a small hen's egg, containing in its midst the piece of bone exhibited, was expelled through the mouth. A great hollow was now observed at the floor of the nostril, with deficiency of part of the vomer, and also of the left middle turbinated bone. From this time all the distressing symptoms of ozœna disappeared as if by magic, and the

exposed and denuded bone was seen with the aid of the rhinoscope to be covered with granulations, and cicatrization rapidly going on. When last examined, in September, no ulceration was visible; the parts had completely healed; but the depression caused by the loss of parts was distinctly visible. He then went to the Highlands of Scotland, and has remained in excellent health to the present time.

Besides careful and persistent topical treatment, the internal use of preparations of iodine and bichloride of mercury was resorted to, to facilitate the cure. The removal of the offensive odour could always be effected by the vapour of iodine, not employed in a too concentrated form. The general health and strength were attended to by a supporting, yet not too stimulating, system of diet and regimen.

Dr. Gibb, 1*st of November*, 1864.

---

2. *Two cases of depressed fractures of the skull, for which no operations had been performed.*

The patients, both adults, made good recoveries, and died many years afterwards from causes unconnected with the injuries received.

In one case the depressed fracture, situated in the left half of the frontal bone, had been firmly consolidated, and its sharp edges bevelled off. In the other case the fracture was in the right half of the frontal bone. The cavity, about one inch and a half long by one inch broad, was filled up by a firm membrane, which was, with the exception of a small part, converted into true bone.

Mr. W. F. Teevan, 1*st of November*, 1864.

---

3. *Fracture of skull, with discharge from the meatus auditorius externus.*

James T, æt. 3, a well nourished boy, was admitted into the Great Northern Hospital, under Mr. Gay's care, on the 13th of June, 1864, with fracture in the left temporo-parietal region of the skull.

The boy fell out of the arms of a man on horseback; the horse reared and fell on the child.

He was brought into the Hospital, in a state of unconsciousness, with indications of compression, but without any signs of paralysis. There was also very considerable venous hæmorrhage from the left ear. In the course of a few hours after admission a swelling of considerable size

showed itself over the squamous portion of the temporal bone, which made it impossible to discover the nature and extent of the injury.

14*th*.—Child more conscious. Bleeding continues, with occasional vomiting; dilated pupils, and feeble, slow pulse.

From this date the symptoms of compression declined; but the child became extremely restless. The discharge from the ear continued in abundance, but on the 18th it became sero-sanguinolent, and on the 22nd offensive and simply serous. On the 24th, the swelling, which remained about the same size, but had become painful since the 22nd, was punctured, and about two ounces of fetid, bloody fluid were let out. The child now took his food, was less restless, and ceased to complain of pain. The skin became cool, the bodily functions were regularly performed, and the discharge from the ear had ceased.

On the 4th of July he was moving about the ward, apparently convalescent. The sister, however, observed at times some converging strabismus of the left eye.

On the 8th of July he suddenly began to vomit, and became unconscious, and his pulse was quick and feeble. On examination, the scalp was observed to be slightly raised, about the size of a crown-piece, at the distance of about an inch and a-half behind the ear. As the swelling increased, and the symptoms became more urgent, it was opened on the 9th, and a large quantity of pure serous fluid, followed by a very small quantity of pus, was let out. A probe discovered a large surface of bare bone, but not depressed. From this time the child wasted rapidly; consciousness entirely left him; the pupils became immovable and dilated; and he died on July 12th, just thirty days after the accident.

On *post-mortem* examination, the child was found to have suffered two severe fractures of the skull on the left side, with commensurate injury to the dura mater, the lateral sinus, and the brain-tissue in juxtaposition with it.

Beginning from the squamous portion of the temporal bone, the first of the fractures was traced downwards in front of the external meatus, through the Gasserian fissure, across the base of the zygoma, along the course of the spheno-petrosal suture, to the foramen lacerum medius. Above, it extended upwards and backwards, and just before reaching the squamous suture, it starred in two directions—one in continuance of the original track, the other forwards along the line of the squamous suture. These two fissures were united by a third, somewhat higher

up in the parietal bone. Thus a triangular portion of the skull was isolated from its marginal connexions, and was lying loose on the dura mater.

The second fracture was in the occipital bone, with loss of bone either by comminution or absorption. It led to the lateral sinus on the one hand, and to the petro-occipital fissure on the other. The dura mater was stripped off the bone to a considerable extent. There was also a very considerable indentation of the parietal bone without fracture, as though it had been depressed by a man's thumb. There was no injury to the petrous bone.

The *pericranium* was detached from the temporal and parietal bones over a considerable area, corresponding with the lines of fracture and loosened portions of bone; and in the interspace thus created, the collection of fluid that was *first* let out took place; whilst in that between the pericranium and the fractured occipital bone, the *second* collection was formed.

From the first of these sub-pericranial spaces, a narrow sinus—still beneath the pericranium—led forwards and then downwards to the margin of the meatus auditorius externus, and then into the meatus itself by a rent in the tissue which connects the auricle with the bone. Through this channel, the bloody fluid passed which flowed from the ear during the early days after the accident. But whence did *it*, as well as the *serous fluid* which was subsequently evacuated, originally spring? Inside the skull the fractures led to the base of the brain. The dura mater was stripped off the bone along their course, and contiguous to the first fracture, the lateral sinus, down to the jugular foramen, was found to have degenerated into a pulpy mass, which enclosed a clot of semi-decomposed blood. The sinus had been lacerated by the accident, and the *aural* discharge evidently had its source in this vessel. Further changes took place; the brain-tissue in the neighbourhood became mixed up by adhesions with the remains of the lateral sinus; the whole at length softened, and, with the dura mater, gave way, thus opening a track to the contiguous sub-arachnoidean space, from which cerebro-spinal fluid welled up in considerable quantities, and from which the *second* collection appeared unquestionably to have had its source.

There was fluid in the ventricles, and pus on the Gasserian ganglion, on the root of the seventh pair of nerves, and on the left choroid plexus.

These details have been given, in order to show the possibility of bloody discharge taking place through the ear from the interior of the

skull, other than by fracture of the petrous bone, a route so admirably described by Mr. Hewett. Mr. Gay, *15th of November*, 1864.

---

4. *Case of excision of the head of the right humerus and glenoid cavity of the scapula fifty years before death.*

This case had been communicated to Mr. Fergusson by Mr. George Harday, surgeon, West Haddon.

B. N., æt. 78, by trade a sawyer, a tall, well made man, came under my observation in the year 1844 (then in his fifty-ninth year). A peculiar flattened appearance about the right shoulder-joint, which attracted attention, was explained by the absence of the head of the humerus and articular surface of the scapula.

From his own account, in the year 1812 he received a severe injury to the shoulder-joint; inflammation and suppuration followed; caustics, incisions, and general treatment did not avail to relieve the constitutional irritation.

In 1814, Dr. Locock, assisted by Dr. Kerr, at the General Infirmary, Northampton, removed the carious head and about an inch of the shaft of the humerus and the glenoid cavity of the scapula. The man made a good recovery, and for some years after followed a lighter occupation than his laborious calling; he, however, resumed his trade, and the narrator has often seen him wielding his axe to prepare the butt of a tree for the saw-pit. The power of the right arm was all underhand, and when the axe was raised the left arm was the elevating member. As he had promised to bequeath to me the shoulder, he enjoined his friends to inform me of his death. The parts were hurriedly removed the day after his death, the 21st of April, 1864, in the presence of his relatives.

Before turning back the skin from the flattened shoulder, three deeply attached cicatrices presented themselves. The deltoid muscle was small; the supra-spinatus and the other muscles were much wasted. The part from which the glenoid cavity was excised will be seen to be bifid; the ligamentous connection of the shaft of the humerus to the scapula is in the line of the greater tuberosity, the unattached portion in that of the lesser.

For fully thirty-five years this man's arm did him useful service.

Mr. Fergusson, *6th of December*, 1864.

---

5. *Elbow-joint, three years after successful excision.*

Mr. Henry Smith exhibited a preparation showing the parts removed after death from the arm of a boy, æt. 7, on whom, three years previously, he had performed excision of the elbow-joint, in King's College Hospital. The boy, after his recovery, was able to use his arm well, in fact his mother stated that the operated limb was more serviceable to him before his death than the other. On examination of the parts, the following was the condition:—The ends of the humerus, ulna, and radius, were well knit together by a strong fibrous anchylosis, there being distinct but limited motion. The head of the radius was very movable. The tendon of the biceps was distinctly made out inserted into the tubercle of the radius, and the brachialis anticus tendon, as well as that of the biceps, was very distinct.

Mr. Henry Smith, 20*th of December*, 1864.

---

6. *Sections of skulls showing the incorrectness of applying to the inner table of the skull the expression "Lamina, vel tabula, vitrea."*

In nearly all anatomical and surgical works it is stated that the inner table of the skull is more brittle than the other, and it has hence been designated the "Lamina, vel tabula, vitrea." The facts which have given rise to the above supposition are, firstly, when a foreign body enters the skull the inner table will always be found more injured than the external; and secondly, fracture of the internal table, without any injury to the external, sometimes occurs from violence applied externally. The above facts do not result from the inner table being more brittle, but depend on other causes.

The reason why the inner table is found more damaged than the outer, when a bullet enters, is because the aperture of exit is always larger than the aperture of entry, whether the bullet be fired from the inside or outside of the skull, and the causation of such fact is to be found in the following proposition:—*The aperture of entry is caused by the penetrating body only, whilst the aperture of exit is larger than the aperture of entry, inasmuch as it is made by the penetrating instrument plus the fragments of bone driven out of the proximal table and diploë.*

When a bullet strikes the external plate, from without, it is the only body which makes, and passes through, the aperture of entry in that table; whereas the bullet and the pieces of bone which it cuts out of

the external table and diploë are all driven in upon the internal table, fracture it, and finally pass through it.

Woodcut 17.

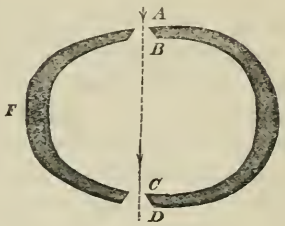


Fig. 17 is a horizontal section of the skull, made through the plane of the gunshot holes, and it will explain the following experiment:—If a bullet be fired with a full charge of powder from a revolver close, and at right angles, to the external and lower part of the parietal bone, A, it will pass through that bone, traverse the brain and its membranes, and finally emerge from the head at a corresponding point in the left parietal bone, D. There are therefore four openings in the skull—the aperture of entry, A, and of exit, B, in the right parietal bone, and the aperture of entry, C, and of exit, D, in the left parietal bone.

By some it would be stated that the aperture of exit, B, in the right parietal bone, is larger than the aperture of entry, A, in the same bone, because the bullet had lost some of its momentum in passing through the external table and diploë, and therefore that, as it strikes the internal plate with diminished power, it makes a larger opening. Now if this explanation were true, then, *à fortiori*, the aperture of entry, C, in the left parietal bone will be larger than the aperture of exit, B, in the right parietal. But what are the actual facts of the case as seen in the experiment? Why, the aperture of entry, C, in the left parietal bone, although made by the same bullet, is actually smaller than the aperture at B. Not only is it smaller, but it is clean cut and regular. This therefore conclusively proves that one supposed cause, loss of momentum, can have nothing whatever to do with causing the aperture at B to be larger than that at A.

It is manifest also, that the greater size of the aperture, B, in the internal plate, is not caused by its greater brittleness, for it is seen

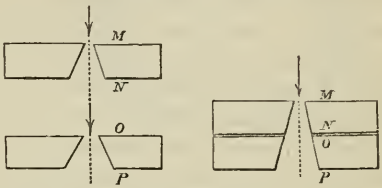
that when the bullet crossed over to the other side it made a small clean cut hole, C, in the internal plate, resembling that in the external plate, A.

It may be stated that B is always larger than A, that D is always larger than C, that C is always smaller than B; sometimes C is the same size as A, and now and then a little larger than it.

Now, why is B larger than A, and C smaller than B? When the bullet cuts out the pieces of bone from the external table, A, and the diploë, it not only drives them forward, but it also tends to separate them, and cause them to exercise lateral pressure on all the bone contiguous to their parts, for, as the *vis viva* of the bullet is very much greater than the *vis viva* of each of the fragments, it must follow that the bullet, in its endeavours to outstrip the fragments, not only presses them forwards, but also pushes them to either side; and thus it is that the inner table, being struck by a disc composed of fragments of bone whose surface is larger than that of the bullet, has a larger hole made in it than that in the external table which was struck by the bullet only. C is smaller than B, because it is made by the bullet only. This is how it is that the aperture of entry in the left parietal bone is smaller than the aperture of exit in the right parietal, for the fragments of the external table and diploë of that bone make the aperture of exit in the internal table larger than the aperture of entry, but they have no influence whatever on the second aperture of entry in the left parietal bone. The smaller the hole the bullet makes in the proximal table, the larger, comparatively, will be the aperture in the distal plate, for the narrower the path the bullet makes for itself the greater pressure it will exercise on all before it. Thus it is that there is but little relative difference between the openings of the wound made by a bullet whose velocity is low, although that wound may be very large; in fact it will generally be found that the larger the wound the less difference in size between its apertures. The experiment above related was repeated seven times, and, in order to obtain the results described, it is necessary that the head be fixed, that the skull should be perforated at right angles by the same bullet at two points where the bones are exactly similar as regards relative thickness, position, &c., and also that the bullet should not alter in shape in passing through the first side, for, should it become flattened, the conditions are at once altered, and hence, the second side being struck by what is now an entirely different weapon as regards shape, we cannot draw any correct inference

from such results. The use of iron bullets almost entirely prevents the above fallacy from taking place. The experiment can be very well exemplified on two well planed planks of dense wood, each about one inch thick (fig. 18). If one plank be fixed a few inches behind the

Woodcuts 18 and 19.



other, and a shot fired through both of them, it will be found that the aperture of entry, M, in the first plank, is small and regular, whereas the aperture of exit, N, in the same plank, is very much larger and ragged (Fig. 18). The aperture of entry, O, of the same bullet, into the second plank, will be found cleanly cut and very much smaller than the aperture of exit in the first plank. This results from the fact that the fragments driven out of the first plank have no influence whatever on the second plank, which is separated from it. If, however, both planks be brought together, firmly braced (Fig. 19), and a shot fired through both of them, we shall have different results, for the second plank being close to the first one, is acted on by the fragments driven out of it, and it will therefore be found that the aperture of entry, O, in the second plank is now large and irregular, clearly showing that the fragments cut out of an aperture of entry are the active agents in making the aperture of exit larger and irregular.

The second fact which had given rise to the supposition that the inner surface of the skull was more brittle than the external was that fracture of the internal table only, without any injury to the other, sometimes occurred from violence acting on the exterior of the head, and the fracture was stated to be caused by the comparatively greater brittleness of the inner table. It was said that the very occurrence of such a fracture conclusively proved that the inner table was more brittle than the other.

Now fracture of the internal table only, does not arise from any supposed greater brittleness of that plate, but occurs in obedience to a

well known physical law—that fracture commences in the line of extension, not that of compression. If it were true that the brittleness of the inner table was the cause of its fracturing, then it would follow that, if violence were applied to the inner surface of the skull, it would be impossible to produce fracture of the external table only without any injury whatever to the inner. Now what are the results of my experiments on this point? Why, they show that, if the inside of the skull be struck, the external table can be fractured without any injury to the internal table; thus proving that the alleged brittleness can have nothing to do with the causation of the fracture. I give the following details of an experiment which any one can, with a little practice, perform. A skull-cap, stripped of all its soft parts, with a wet cloth inside it, is to be laid with its convexity in the palm of the left hand, which is to be protected with several layers of a wet cloth, to obviate an inconvenient amount of pain. If the inside of the skull be now struck with a hammer with a slight degree of force, fracture of the external table will be produced without any fracturing or fissuring of the inner. I would here refer to a specimen, which is quite unique, of a certain fracture of the skull which has never been described by any surgical writer. In Guy's Hospital Museum, No. 1,082[70], there is the calvarium of a man who committed suicide by shooting himself. The bullet entered the skull in the right temporal region, traversed the brain and its membranes, struck the inside of the left part of the frontal bone, and remained imprisoned in the cranial cavity. At the spot, on the inner surface of the frontal bone, where the bullet struck, there was a black mark, but no fissure nor fracture; but at the corresponding point outside there was a starred, fissured fracture of the external table only. Here, then, was produced accidentally a similar kind of fracture to that which I had caused experimentally.

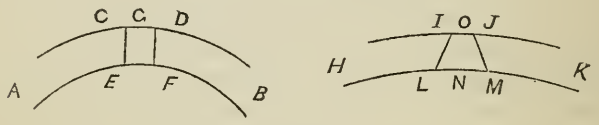
Thus, therefore, whether the inside or outside of the skull be struck, fracture of the distal table only, without any injury to the proximal table, can be produced in either case.

I will now show the causation of the above. If a stick be bent across the knee until it commences to break, it will be found that the fracture begins, not at that spot where the knee is applied, but at a point exactly opposite on the other side, and the fracture commences there in obedience to a well known physical law, that when pressure is applied to a body till it breaks, the fracture commences in the line of extension, not that of compression. Now when a stick is bent, the

atoms along the proximal curve at which the pressure is applied are brought nearer together or compressed, and the atoms along the distal curve are separated or extended. Therefore, if the pressure be continued till the stick breaks, it follows that the rent or fracture must commence at that spot in the distal curve where the greatest extension is going on, which point will be found exactly opposite to where the pressure is applied.

The annexed diagrams show the rationale of fracture of the internal table only, produced by a blow on the outside of the skull.

Woodcuts 20 and 21.



Let A B, fig. 20, be a section of a skull. Draw two vertical lines, C E and D F, parallel to one another. Now, if pressure be applied at G, temporary depression takes place, and the bone assumes the shape of H K, fig. 21, and the lines C E, D F, are no longer parallel to each other, but converge towards each other at the upper surface, I L, J M, so that the distance from I to J is less than that from C to D; but the distance from L to M is greater than that from E to F, signifying that the atoms of bone in the upper surface from I to J have been brought nearer to each other, or compressed, whilst the atoms of bone in the lower surface, from L to M, have been extended or separated from each other; therefore, if any fracture take place, it is clear it must do so in the line of extension L M, and at that point in the line where the greatest extension is going on, which is at N, exactly opposite the spot, O, where the pressure was applied.

Proof.—Take a cane slightly bent, say A B, fig. 20, and insert two pins or wires, C E, D F, vertically, and parallel to each other—the more the pins project at each surface the more manifest will be the result. Exert pressure at G till the cane is made flatter, H K. It will now be found that the wires are no longer parallel to each other, but converge along the upper surface, so that the distance between them from I to J is less than from C to D; but the distance from L to M is greater than that from E to F, showing clearly that the atoms along the line I J have been compressed and brought nearer to each other, whilst

DESCRIPTION OF PLATE X.

Illustrating Mr. Buxton Shillitoe's case of Fibrous Tumour near the angle of the Lower Jaw (p. 223).

Fig. 1. shows the form and situation of the tumour, of the natural size.

Fig. 2. Second molar tooth, the fang of which projected into the cavity occupied by the tumour.

Fig. 3 shows the microscopic structure of the growth, with the islands of calcification; natural condition.

Fig. 4. The same, after addition of liquor potassæ.

Fig. 5. The same, after addition of hydrochloric acid.

Figures 3, 4, and 5 are magnified 150 diameters.

Fig 2.

Fig 1.

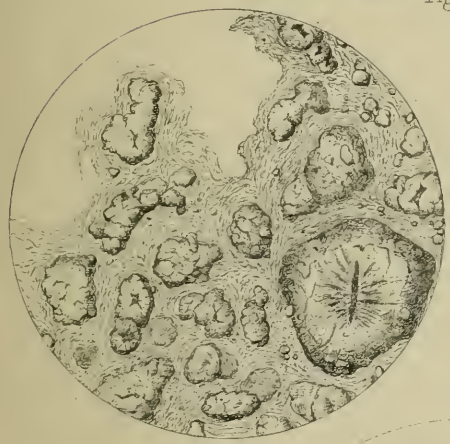


Fig 3.

Fig 4.

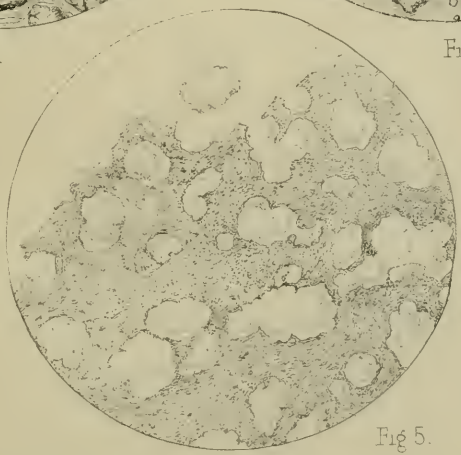


Fig 5.

those along the line L M have been extended; consequently, if any fracture take place it must commence at N. If the pressure on the cane be continued till it breaks, it will be found that it commences to break at the point N.

Mr. W. F. Teevan, *20th of December*, 1864.

---

7. *Fibrous tumour from near the angle of the lower jaw.*

The specimen was removed from near the angle of the lower jaw of a young woman, æt. 26, who was under Mr. Shillitoe's care, at the Great Northern Hospital. It had been growing for fifteen months, and when first seen by Mr. Shillitoe, four months ago, was about the size of a large nut, hard, painless, irregularly oval, and slowly increasing. At the time of the operation, it had increased to the size of a large French walnut, and it projected considerably above and anterior to the angle of the jaw, it was irregularly rounded, and yielded slightly to firm pressure; it had also become painful.

An attempt was made, thinking that it might be a bony cyst, to produce absorption by cutting through it in the mouth; but it was found to be filled with a dense structure, and the endeavour to produce suppuration in it, by firmly plugging it with lint, failed. Six weeks after this, it was removed by reflecting a flap of skin, &c., from the surface of the tumour, cutting through the thin shell of bone and enucleating the tumour with the finger in three portions from its bony capsule. It left a perfectly smooth cavity, except that the fang of the second molar tooth projected into it; this and the thin walls of the cyst were removed.

The tumour on section was firm, bluish, glistening, almost cartilaginous, and slightly gritty.

Under the microscope, it was found to consist of a very dense fibrous tissue, studded with multitudes of isolated points of calcification. The fibres were so matted and coherent that it was only at the edges of some specimens that they could be made out: they were of the nature of white fibrous tissue. The little islands of calcification, varying from $\frac{1}{100}$th to $\frac{1}{1500}$th of an inch in diameter, consisted of multitudes of oval and spheroidal bodies irregularly distributed in the mass, the outline of each being dark and the centre brilliant (*see* Plate X.). Some of the calcification islands when mounted in Canada balsam displayed dark cavities resembling bone lacunæ. The action of caustic alkali

upon a thin section rendered the fibrous tissue transparent, and displayed the calcifications more distinctly; diluted hydrochloric acid applied to a microscopic section rapidly dissolved the earthy matter, with abundant evolution of bubbles of carbonic acid.

These calcifications were not interstitial deposits, but local impregnations of the animal tissue with the calcareous element. The dissolving out of the lime earth did not leave interspaces, but a decalcified animal basis, rather more transparent than the surrounding tissue. All these appearances have the closest possible resemblance to certain changes which occur in a human tooth-pulp, that has been the subject of chronic inflammation, and which were described by Mr. Salter in the Ninth Volume of the *Guy's Hospital Reports*. One figure of his much resembles a section of this tumour.

Mr. Buxton Shillitoe, *7th of March*, 1865.

---

8. *Skull-cap showing congenital deficiencies of bone.*

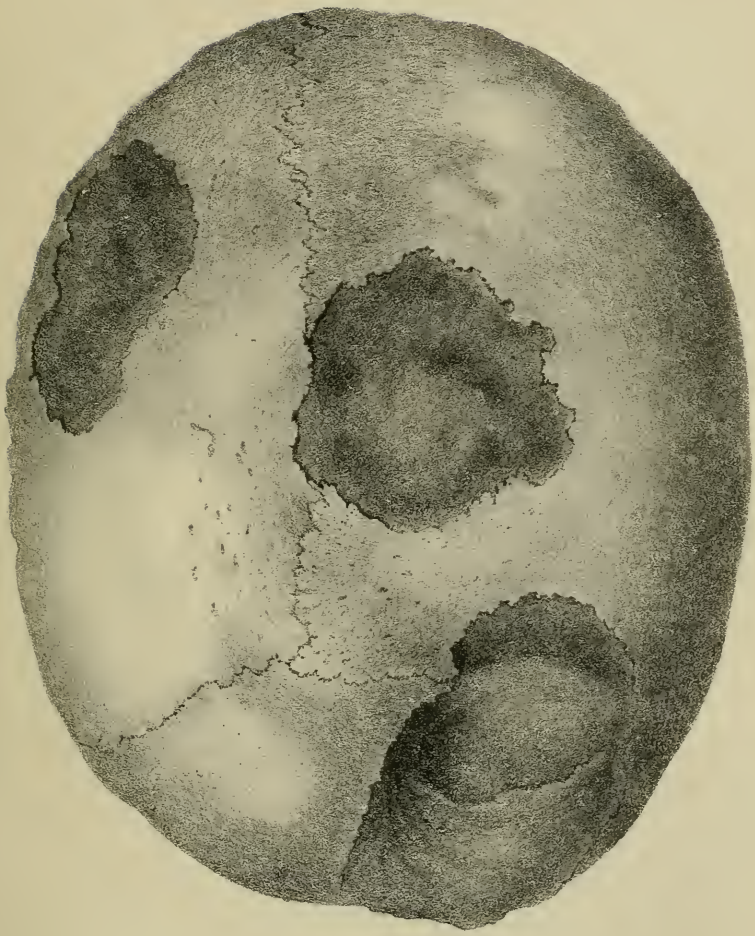
The specimen was removed from a child, 4 years and 6 months old, who came under observation, some months before death, with impetigo of the scalp and an abscess over the occipital region on the right side. On examining the abscess, with a view to its evacuation, it was observed to pulsate, and to exhibit the ordinary respiratory movements of the brain, which led to the discovery of a large hole in the bone beneath it. Subsequently two other deficiencies in the bone were found, one in each parietal region; these latter did not pulsate, nor were the other movements of the brain perceptible through them. The abscess over the occiput was not opened. The impetigo was cured, and the child died some months afterwards of whooping cough.

Through the kindness of Dr. Bagshawe, under whose care the patient was at the time of death, I was enabled to obtain the specimen, which comprises almost the whole vault of the skull (*see* Plate XI.). Towards the right side of the occipital region is a large hole in the bone, with uneven edges, measuring three inches by two inches. The deficiency is chiefly in the occipital bone, but it also encroaches beyond the suture into the parietal bone. Over this opening is situated the sac of an abscess, the contents of which at the time of the child's death had partially dried up.

Another hole is situated in the right parietal bone, close to the sagittal suture. It is nearly circular, and measures two inches by two inches.

DESCRIPTION OF PLATE XI.

The plate illustrates Mr. Thomas Smith's case of Congenital Deficiencies in the Bones of the Skull-cap (p. 224).



Tuffen West lith. ad nat.

W. West imp.

It does not encroach upon the aforesaid suture, though it is only separated from it by a rim of bone. A third oval opening into the skull is in the front part of the left parietal bone, just between the temporal ridge and the sagittal suture. It does not encroach on any suture, and its diameters measure two inches and one inch respectively.

These dificiencies in the bony structure are filled up by firm fibrous structure, formed by the pericranium on one side and the dura mater on the other; while between these two membranes there seems little, if any, intervening tissue. The other parts of the skull are well formed and thoroughly ossified. The margins of the openings are abrupt and well defined; they are irregular in outline, but the outline does not resemble that of the holes left by deficiencies of ossification in the line of sutures to be subsequently filled by triquetra, as they are called.

It is worthy of remark that two of the openings in the skull are in close proximity to the earliest points of ossification of the parietal and occipital bone respectively. They are quite clear of both anterior and posterior fontanelles, and they do not trench upon the lines of sutures. They must therefore be regarded as original defects in the earliest stage of bone formation, and not as arrests or interruptions of the fully established process.

The only specimen I have been able to find showing a similar congenital deficiency, except as combined with encephalocele, is in the Museum of Guy's Hospital, where is the skull of an old woman showing a large deficiency in the bone filled up by membrane; it is situated on the side of the occipital region; its margins have the same appearance as those in the specimen above described. I have recently seen, in St. Bartholomew's Hospital, under Mr. Wormald's care, a little boy, with a deficiency in the bony structure of the occipital bone; but here there was a doubt if the opening was congenital.

Mr. Thomas Smith, *4th of April*, 1865.

---

9. *Case of osteo-myelitis, or inflammation of the internal periosteum of the tibia.*

Mr. Henry Lee showed a drawing of a vertical section of the whole bone in this case. He observed that the disease itself probably was not very uncommon, but it was seldom that we had an opportunity of

observing the appearances produced. When the affection was fully developed, we either, as a rule, examined the parts before the disease had attained its height, or after it had come to one of its natural terminations, viz.:—1, resolution; 2, suppuration within the cancellous tissue; or, 3, necrosis.

In the present case, accidental circumstances necessitated the removal of the limb at a time when the disease had become fully developed, and before any secondary consequences had ensued. The patient's name was Richard Wicks, æt. 23, and he was admitted into St. George's Hospital on the 1st of February, 1865, with a compound comminuted fracture of the left leg. The accident was caused by a cab that he was driving being capsized and falling upon him.

On the 3*rd*, there was much tension of the skin, and several large vesicles had formed on the leg. Pulse 104; tongue furred.

On the 25*th*, the wound was quite clean, and the patient was gaining flesh.

27*th*.—He was seized with intense pain in the bone of the leg, so great that at times he would cry out. He said that the pain was of a gnawing character, and seemed to be situated in the bone. The wound now looked unhealthy, and was covered by flabby granulations.

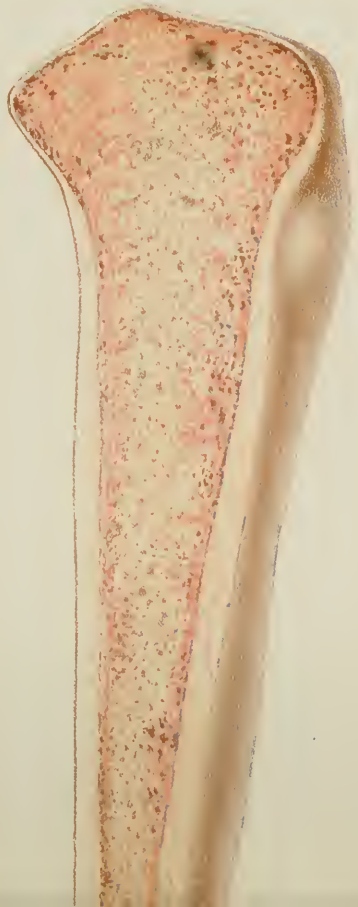
March 3*rd*.—Had a shivering. The pain still continued most severe, especially towards the evening. There was profuse discharge from the wound, and the periosteum was seen to be separating from a portion of the exposed bone.

10*th*.—Had had no more shivering; was evidently getting gradually weaker. The wound had extended to the back of the leg, and now presented a large phagedænic surface as large as the palm of the hand. The pain in the bone continued, and there was a strangeness of manner and language resembling some form of delirium. The leg was now amputated above the knee. The patient rapidly improved subsequently to the operation; but eleven days afterwards, the pulse again became irritable, and there was some pain and swelling about the stump, which had almost entirely healed by primary adhesion. A discharge of matter subsequently took place, and the irritation ceased. The patient was enabled to leave the Hospital on the 26th of April.

On examining the parts after the removal of the leg, indications of incipient ulceration of the cartilages, both of the tibia and femur, were visible; these were, however, very slight. The whole of the internal periosteum of the tibia was much injected. This injection was most apparent near the seat of fracture, where a portion of the shell of the

DESCRIPTION OF PLATE XII.

The plate illustrates Mr. Henry Lee's case of Osteo-myelitis. It shows a section of the Tibia, with abnormal vascular injection of the internal periosteum (p. 226).



J^r Westmacott del

W.West chromo lith^r

bone had been driven into its cancellous structure. The extremities of the bone, and that part of the cancellous structure near the cortex, were also of a brighter colour than the rest. These appearances are faithfully represented in the accompanying drawing by Dr. Westmacott (Plate XII.). On making a section of the lower extremity of the femur, that also was found to be unnaturally injected.

Mr. Henry Lee, *2nd of May*, 1865.

---

10. *Case of fibroid growth in the tibia.*

Michael M., æt. 22, was admitted into the Royal Infirmary, Liverpool, 22nd of August, under the care of Mr. Bickersteth, suffering from a painful thickening of the lower third of his right tibia.

Present state.—The patient is apparently healthy; a labourer; and has led a steady life. Below the middle of his right leg, and extending to within an inch of the ankle-joint, is an enlargement or thickening of the tibia, which feels firm and bony. It is covered by a cicatrix, apparently healthy, but immovably adherent to the structure beneath it. He suffers considerable pain in the leg, which is aggravated at night, and is influenced by changes in the weather.

History.—He states that he has no recollection of having sustained any injury to his right leg, that he has always been well and strong, and that all his relatives have enjoyed good health, no hereditary, cancerous, or strumous affection existing in his family; and he denies having ever had syphilis or gonorrhœa. He first perceived the tumour in May, 1862. It was then about the size of half an egg, and felt hard and fixed; but the skin was movable over it; he experienced constant aching pain in the leg, near the swelling.

He at this time went to a surgeon at Southport, who applied some local treatment to the tumour, and he remained under his care for three weeks, but derived no benefit. In the following June he crossed over to Ireland, and placed himself under a practitioner at Castlerea, by whom an incision was made into the tumour, and subsequently a caustic solution was occasionally applied; but he failed to obtain relief after being a month under this treatment. He now (July, 1862) gained admission into Steevens's Hospital, Dublin, the wound in his leg not having yet cicatrized. In the Hospital the ulcer soon healed, and in a few weeks an operation was performed upon his leg; the tumour appears to have been either trephined or gouged out, and

a fortnight after, he left at his own request, although the wound, which was about the size of half-a-crown, was open. He then resorted to some unqualified man, whom he attended for nearly two months: and at the end of that time the wound on his leg had cicatrized. The patient now (November) returned to England, the thickening of his tibia having considerably increased, but projecting forwards rather less, and the pain continuing as before. For four months he resumed his employment as a labourer, and then the pain in his leg having gradually become worse, he found he could no longer continue his work.

In April, 1863, admission was procured for him into the Southport Convalescent Hospital, where he remained six weeks. He then applied for admission into the Royal Infirmary, June, 1863. Iodide of potassium was prescribed for him in five-grain doses, but no improvement followed its employment. An operation was subsequently proposed, to which the patient refused to submit, and he was therefore discharged, July 21st, 1863. The following year, April 26th, 1864, he was again admitted into the Infirmary; the tumour was observed to have altered but little either in size or character; but he was now compelled to go about on crutches, as he was unable to bear his weight upon the diseased leg. The swelling was about three inches in length, commencing one inch above the ankle-joint. Its surface was flat and regular; the skin over it adherent and somewhat œdematous, presenting the mark of previous operations; it was painful on pressure.

Although the diagnosis was obscure, the disease was supposed to be chronic periostitis, depending, probably on a carious condition of the bone beneath, and it was hoped that a free incision through the periosteum over the whole of the thickened part, and the application of the trepan, to open the interior of the shaft, would relieve congestion and give exit to confined matter, if such existed. Accordingly, on the 3rd of May a free incision was made the whole length of the swelling; but to the surprise of the operator, the knife, instead of being arrested by bone, passed into the substance of the swelling, and completely through the entire thickness of what should have been tibia. There were no spiculæ of bone in the morbid mass; it cut like dense fibrous tissue or softened cartilage. On introducing the finger into the opening thus made, near the margins of the tumour, irregular projections of bone were felt both above and below. The sections of the tumour, as far as could be seen, presented a smooth, glistening, yellowish-white appearances, with here and there patches of a dark chocolate colour, having the appearance of melanosis.

The incision healed most readily, as readily as if it had been made through healthy stucture; and the patient left the Hospital, on the 11th of June, to go into the country, returning on the 22nd of August. It was now discovered that the tibia distinctly "yielded," at the part occupied by the tumour. Amputation was therefore proposed, and the operation was performed below the knee on the 30th of August. The patient made a good recovery, and was discharged on the 8th of October.

On making a longitudinal section of the tibia, it is observed that the lower fourth of the bone, viz., from three-quarters of an inch above the ankle articulation upwards for at least four inches, is converted into a dense white substance, of fibro-cartilaginous appearance. No trace remains at this part of either the compact or medullary tissue, but the substance which replaces it, retains almost the natural shape and form of the healthy bone. On the anterior surface, this abnormal substance extends beyond the natural contour of the tibia, and is covered merely by apparently healthy cicatrix. The section presents towards the anterior surface several melanotic looking spots. The separation between the abnormal growth and the healthy bone is clearly defined above and below.

Mr. E. R. Bickersteth, 16*th of May*, 1865.

Report on the above specimen.—The preparation consists of a vertical section of the lower half of the bones of the leg, with their soft coverings. The bony tissue of the tibia, for about four inches above the lower epiphysis is replaced by a white, slightly translucent, tough fibrous mass. The hard cortical tissue of the shaft of the tibia is deficient at the tegumentary and interosseous surfaces, in which situations the mass replacing the tibia runs into and blends with the skin and cicatrix on the one side, and invades the muscles on the other. New bone, distant and distinct from the original bony tissue, has been formed in the cicatrix. In the upper part of the mass, quite within the line of this interosseous surface of the tibia, the uniformity of the section is broken by a faint brown streaking, which proceeds from the presence of striped muscle, fibres of which, in decreasing number, and in an increasingly atrophied state, are met with from the surface nearly to the centre of the mass. The sarcolemma alone of the most wasted fibres remains, collapsed and folded, and containing only oil-globules and granular corpuscles. In parts from which these fatty products are absent, the transparent empty sheath exhibits a very distinct chequered striation, an appearance

which I have not previously observed. In several places the section of the tumour has a rusty colour referrible to local hæmorrhages. The finer structure exhibits fibre-cells and a fibrillated interstitial transparent substance. Anatomically the tumour ranks among the new growths allied to connective tissue.

Mr. J. W. Hulke, 16*th of May*, 1865.

VII.—DISEASES, ETC., OF THE ORGANS OF SPECIAL SENSE.

1. *Two cases of black cataract.*

Case I.—On the 28th of September, 1864, I was consulted by a gentleman, æt. 48, who had received a blow on the left eye sixteen years previously; severe inflammation followed; a cataract of the usual white colour formed; and in the course of two years the sight was gradually lost. Eighteen months ago he suddenly found that he could again see objects, even newspaper print, and that the cataract had disappeared. Next day there occurred a very violent inflammation, and the sight was again entirely lost. Since that time he has been incessantly tormented by severe stabbing pains in the eye and over the left side of the head, and repeated attacks of internal ophthalmia.

On examination, I found that there was no conjunctival congestion; the cornea was clear; the pupil of medium size, but immovable; he could not perceive light; I did not consider it necessary to use the ophthalmoscope. From the symptoms and previous history, I judged that the lens had undergone calcareous degeneration and then become displaced, and that it now irritated the eye like a foreign body. As he had already undergone much useless treatment before I saw him, I recommended enucleation of the globe, to which he at once submitted. No particular symptoms appeared, and in a few days he was perfectly well.

On making an equatorial section of the eyeball, I found the vitreous humour quite fluid, the choroid much atrophied, and the lens floating hither and thither at the bottom of the vitreous space; the iris appeared at some parts much thinned. The lens was of a jet-black colour by reflected, and of a deep blood-red by transmitted, light, though its equa-

torial margin for perhaps half a line was whitish; it felt very hard and heavy; it was of medium size, and appeared to be still in its capsule. No trace could be perceived of any effusion of blood in the eye.

Both the lens and eye were placed in dilute spirit. The lens is now only about half its original size, and its colour has, I think, slightly changed.

Case II.—On October 14th, 1864, G. L., a labourer, æt. 35, from near Burnley, was admitted into the Manchester Eye Hospital. Last July his left eye was injured by a blow from a piece of coal.

There is now moderate conjunctival injection; the pupil is large and motionless; the iris is muddy and tremulous, and there is a small round hole in its outer portion; in the centre of the pupil there is a piece of capsule of a dirty yellow colour; the rest of the space is filled by a perfectly black lens; the tension of the eyeball is somewhat increased; the perception of light is moderate; he sees the movements of a hand to the distance of two feet and a-half.

In a few days I made a good-sized iridectomy at the inner side of the eye. Further examination showed that the lens was considerably behind the iris, from which I concluded that its thickness was diminished, that its periphery was convex, showing that there remained, at all events, something more than thickened capsule, and that its extreme margin at the equator of the lens was still of a greyish hue for about a quarter of a line in breadth. By throwing a powerful light on the sclera and edge of the cornea at the inner side of the eye, I could see, through the small hole in the outer part of the iris, the red reflex of the fundus; by looking very obliquely upwards, inwards, outwards, or downwards, between the iris and the lens, I also succeeded in seeing the red reflex.

On November 15th, I made a flap of a little less than half the cornea and extracted the lens, which, as the specimen shows, exactly agreed with the diagnosis. No accident followed, but the sight remained very imperfect, a fact explained by ophthalmoscopic examination, which showed that the vitreous humour contained numerous floating shreds and was so generally hazy that the optic disc could only just be perceived, whilst the vessels on the fundus could not be seen. No foreign body could be found.

The lens was placed in glycerine, and appears to have undergone no further change.

Remarks.—A professor at Jena, Rolfink, was the first, so far as I am aware, to mention the occurrence of black cataracts; this was in the year 1664.* After that time various observers recorded cases which they considered to deserve the title; and in 1832 Warnatz collected all the scattered facts and opinions, and formed with them an excellent monograph.†

In former times, the question most interesting to practitioners was that of diagnosis, for owing to the blackness of the pupil, this form of cataract was readily overlooked. This difficulty has now, however, been entirely overcome by the introduction of the ophthalmoscope and the general use of atropine and oblique illumination.

In other respects further researches are still required, especially in regard to the minute anatomy. So far as has yet been observed, it appears that there are two essentially different modes in which the blackness is induced; one by the introduction of pigment, which is probably derived from the blood, the other by a species of condensation of the ordinary senile cataract.‡

I may just allude to another point. It is generally admitted that black cataracts are rare; yet I am inclined to think that they are really more uncommon than is generally supposed. Many cases have been thus denominated which would with greater propriety have been said to be of a deep brown colour; thus Sichel has published, in his great work, a chapter on black cataract, where he describes only the form of senile change in which the lens is of a deep or mahogany brown, as may be seen by comparing his description and plates.§ From the few words in which Mackenzie alludes to the subject, it seems very doubtful whether he has ever met with a case; and it is certain that many celebrated practitioners, such as Scarpa, Delpech, Demours, and Dupuytren, never observed it. Not many years ago, Mr. Walton read before the Medical and Chirurgical Society some *Remarks on a case of Black Cataract;*‖ a denomination hardly correct, for the lens, even when within the eye, was only "of a very deep brown colour;" and it is known that a brownish coloured cataract within the eye appears of a darker hue than after its extraction. Mr. Hulme has re-

* Diss. de Cataracta. Jenæ, 1664.

† G. H. Warnatz, Diss. de Cataracta Nigra. Lips., 1832.

‡ See the cases of Petrequin, Ann. d'Ocul., 1850, xxiii., 172; Blot, Gaz. de Paris, 1852, 26; Stellwag von Carion, Die Ophthalmologie, &c., vol. i. p. 750; Alessi, Arch. d'Ophth., 1854; von Gräfe, Arch. für Ophthalmologie, vols. i. and ii., &c.

§ Iconographie, pl. xvii., fig. 1, 1*a*, 1*b*.

‖ Association Med. Journal, 1855, p. 1092.

corded in the Fourteenth Volume of the *Transactions* of this Society, p. 233, a case in which a lens after extraction "appeared of the full size, with a deeply maroon-coloured hard nucleus, almost black in the centre, and surrounded with much soft white matter, with calcareous deposit on its surface." Mr. Dixon says,* "Occasionally the lens is found of so deep a brown that it is called a 'black cataract.' In very rare instances, however, absolute blackness is met with;" and in a note he adds, "In my first edition I asserted the contrary, but within a few weeks after the publication of the volume, a cataract was removed by one of my colleagues which, when extracted, appeared entirely black. Before the operation, there had been no suspicion of its peculiar nature. It had seemed to be of a deep colour within; but several fine whitish lines radiated on its anterior surface, formed, no doubt, by slight earthy deposits just inside the capsule."

In conclusion, I may state that I know of no case hitherto recorded in this country, in which the *whole* lens has been of a *perfectly* black colour. Mr. Thomas Windsor, 20*th of December*, 1864.

Report on the above Specimens.—The very dark colour of the lenses proceeds from a brown tinging of the lens-fibres and not from the presence of free granular pigment. The nature of the colouring substance I am not able to determine. ..

Mr. J. W. Hulke, 7*th of February*, 1865.

---

2. *Sebaceous tumours in the tympanum.*

The case was peculiar, inasmuch as, instead of a single laminated mass of epithelium cells, enclosed by a membrane, two tumours were present in the form of small rounded bodies of a glistening white aspect, not attached to the walls of the cavity, but embedded in a semi-membranous pultaceous mass which filled it. The mass itself appeared to be of the same character as the smaller tumours, but to have undergone decay. The membrana tympani was thick, white, and fallen in, and at its posterior part was a round perforation with smooth edges. The bone was not diseased, but the roof of the tympanum was thick and dense. The external meatus contained thickened flakes of epidermis. Eustachian tube pervious. The vestibule contained much more than the usual amount of otoconia. The nerves distributed within it were small and

* *Guide to the Practical Study of Diseases of the Eye*, second edition, p. 229, 1859.

of fibroid appearance, and some of the epithelium cells were fatty. In the semi-circular canals were numerous large-sized oval bodies lined with epithelium; these were not found in the opposite ear. In the cochlea the "teeth" appeared small and their outline indistinct. The patient was a man, æt. 56, who died in Guy's Hospital from cancer of the liver. He could hear a distinct voice within a foot of the ear: had been deaf in that ear (as he said "from colds") for upwards of twenty years; neither pain nor tinnitus. The left ear also had at one time been deaf, but had been cured by syringing. In this ear (the hearing of which shortly before his death was good, though not acute) the tympanum contained a large number of fine, but firm adhesive bands, which surrounded the ossicula in all directions. The ossicula, however, were fairly movable. The labyrinth appeared healthy.

Mr. Hinton, 17*th of January*, 1865.

Report on the above Specimen.—The membrana tympani is much sunk in; its surface is white from an accumulation upon it of thin membranoid laminæ, which under the microscope present the appearance of layers of large flat cells. At its upper and posterior part is a circular orifice about two lines in diameter, with smooth edges. This leads into a small cavity about a line and a-half in depth, the internal wall of which is constituted by the inner wall of the tympanum, and is also covered with similar white laminæ. The head of the stapes lies in contact with the anterior border of the cavity, within which this bone lies exposed, but not distinguishable by the eye on account of the white mass in which it is enveloped. It is moderately movable. On examining the tympanum from above, the malleus and incus are seen to be disarticulated. The tympanic cavity is occupied by a firm shreddy mass of brownish colour, which extends into the mastoid cells. Under the microscope this mass appears to consist of a faintly fibrous substance, mixed with numerous shrivelled and degenerated blood corpuscles. Its appearance resembles that of an old effusion of blood and fibrin. Loosely seated upon this mass is a small, oval, white body, of a firm, elastic consistence, strikingly resembling an ant's egg. (The second body, which was of similar appearance, but somewhat larger, had become detached.) This body was found to consist of thin layers of flattened and shrivelled cells, corresponding with those described as lining the cavity first mentioned, and enclosed in a thin investing membrane. Its structure accordingly answers entirely to that of the sebaceous tumour as met with in other parts of the body. The difference of

this case from those which have been previously reported lies in the fact that the two small tumours appear to have been developed, not in the external meatus, but within the tympanic cavity. The exact source and mode of their origin there does not appear to be sufficient evidence to determine. Besides these two separate tumours, however, a sebaceous tumour has been developed on the external surface of the membrana tympani which it has penetrated, and has advanced into the tympanum. Connected with this growth there appears to have been an effusion of plastic matter and blood, and the ossicula have been detached from each other. The Eustachian tube is healthy.

Mr. Joseph Toynbee,
Mr. Thomas Smith,
Mr. James Hinton, *7th of February*, 1865.

---

3. *Melanotic tumour of the orbit.*

The tumour weighed one ounce one drachm and a-half, and had been removed ten months previously, from a woman, æt. 62. It had then been growing eight or nine months. The eye-ball was protruded from its socket, but not apparently enlarged itself. It was insensible to light; the interior of the eye was illuminable, but no details could be observed. The patient had suffered great pain, which she referred to the temple and side of the head. Mr. Laurence removed the tumour, together with the eye-ball, which was found to be firmly embedded in its substance; the growth was enveloped in a fine pseudo-cyst of cellular tissue, and presented all the obvious and microscopical characters of melanotic cancer; the eye-ball itself was free from any morbid deposit whatever; the vitreous humour was fluid; the retina partly separated; the lens, nebulous. The tumour recurred *in situ* in about three months, when Mr. Laurence transferred the case to Mr. Weeden Cooke. The patient died in about three months afterwards, by which time the secondary tumour of the orbit had attained the size of a cricket-ball, and deposits were found within the cranium. Mr. Laurence said he considered this case remarkable for the extremely acute course it had run, differing in that respect from the cases of melanotic cancer of the eye he had hitherto observed, and agreeing more with those of encephaloid cancer of the eye-ball in children. Mr. Laurence, in corroboration of this assertion, instanced a second case of extensive melanotic cancer of the orbit which he had removed some years ago, in which

case no recurrence of the growth had taken place when he saw the patient two years and four months after the operation.

Mr. J. Z. Laurence, 21*st of February*, 1865.

---

4. *Small tumour within the tympanum. Cicatrix (?) of the membrana tympani.*

The preparation was the left petrous bone of a man, æt. 29, who died of heart disease. He was somewhat, but not very, deaf, by his own account, for about three months before death, and had suffered from tinnitus. On the membrana tympani, immediately below the handle of the malleus, was a depressed and thinned spot about two lines in diameter. On examination, the proper tissues of the membrane were found to be wanting, and merely a very thin, transparent lamina was present. At the upper border, above the short process of the malleus, the membrane was wanting to an extent of over two lines. Within the tympanum, in a corresponding position, and embracing the heads of the malleus and incus, there was a firm fleshy mass, nearly the size of a pea, attached to the bone and communicating with the aperture in the membrana tympani. It was not surrounded by a special membrane, and it consisted simply of a finely fibrillated substance, in which were scattered numerous small, dark, and shrivelled cells. There were many adhesions tying together, but not fixing, the ossicula, and there was a little puriform fluid in the upper part of the cavity. In the vestibule the blood-vessels were very large and full, with many free blood corpuscles. In the opposite ear there was a perforation of the membrana tympani at the spot corresponding with the thinned portion of the other.

Mr. Hinton, 4*th of April*, 1865.

VIII.—TUMOURS.

1. *Fibro-fatty tumour of the neck, in a child, successfully removed.*

The patient, a child, æt. 3, was admitted into St. George's Hospital on the 3rd of November, 1864, on account of a tumour on the back of the neck, which had been noticed for about a year, and latterly had been growing rapidly. It had been punctured several times at another Hospital, and was again punctured, on his admission, at St. George's, but

no fluid was found. It was of a roundish shape, unconnected with the skin, and movable on the deeper parts. It felt very soft in some places, with round, hardish lobules in others. It occupied the posterior triangle of the neck on the left side, projecting backwards so as to raise the trapezius, and it ran inwards towards the vertebral column. The sterno-mastoid was slightly raised by it in front, but appeared quite separate from it. Below, it reached to within a finger's-breadth of the clavicle, but was quite separate both from the bone and the subclavian artery. Above, it reached within a finger's-breadth and a-half of the root of the scalp. The child appeared in perfect health. The tumour was removed by a crucial incision; it was enclosed in a capsule of fibrous tissue. The only difficulty consisted in dealing with the parts beneath the trapezius. It was necessary to divide that muscle to a considerable extent, and to cut away the very firm adhesions uniting the tumour to the spines of the vertebræ. Only one small artery, probably the transversalis colli, was wounded. In three weeks (November 23rd) the wound was so far healed, that the child was allowed to go home.

On examination, the tumour, which was as large as a duck's-egg, was found to be composed of very firm fat mixed with fibrous tissue. Some of the lobules were almost exclusively fibrous, but others showed no trace of anything except the usual constituents of a fatty tumour. A large tongue-like lobule had run downwards to the spines of the vertebræ; but, from the presence of an investing capsule, there had been no difficulty in removing the entire mass of disease. The wound healed without any deformity. The points of interest in this case were the rapid growth of the tumour, its non-congenital origin, its perfectly innocent structure, and the ease with which it was removed, in spite of its great size and very deep position. This resulted from the fact of the tumour possessing an investing capsule, as is usually the case in innocent tumours of the neck. In all such cases, by making a free opening in the capsule and using the fingers to separate it from the substance of the tumour, the greater part of the latter can be freed from its attachments with no risk of hæmorrhage or of wounding important parts.

Mr. Holmes, *15th of November*, 1864.

---

2. *Fleshy tumour of the thigh.*

This tumour grew by a broad peduncle from the posterior sur-

face of the thigh, projecting about two inches from the surface. The subject of it was a female, æt. about 40. It had arisen spontaneously as a small projecting tumour about five or six years previously. The patient had pricked it about two years ago, and at the same time endeavoured to expel its supposed fluid contents by pressing it firmly on the edge of a wooden seat. Some amount of painful irritation was produced by this treatment, which, however, subsided in a few days. Within the last few months she has had occasional lancinating pain at the point of puncture; and at that point the tumour presents a small dark-coloured prominence, quite different in appearance from the bulk of its substance.

The tumour was removed, with an elliptical portion of the integument, beneath which were two separate lobules of fat. The elevated portion of the tumour was more condensed, and contained much fibrous tissue. The dark spot before mentioned contained some nucleated cells not met with in other parts of the tumour; and from the character of the pain recently experienced, it is not improbable that malignant degeneration had commenced.

Mr. Brooke, *7th of February*, 1865.

---

3. *Medullary tumours of the leg, from an infant* 17 *months old.*

The specimen was removed from a little boy, an out-patient at the Childrens' Hospital, who came under my care in June, 1864. He was a robust, healthy-looking child, living at Stoke-Newington. When about three months old he fell out of bed, and a fortnight afterwards his mother noticed that his left calf was much larger than the right, and as the swelling did not diminish, she brought him to the Hospital.

When first seen, there was a painless swelling, without heat or redness, and evidently consisting of some fluid, beneath the muscles of the calf. I considered it to be a collection of blood effused from some vessel ruptured at the time of the fall. The boy appeared perfectly well and lively, and moved both legs alike most vigorously. Being unwilling to interfere unless he were suffering some evident discomfort, I merely applied a spirit and arnica lotion, and determined to watch the progress of affairs.

From this time the case was carefully observed, and for some months no change in the limb took place, except that the swelling grew rather firmer, and seemed to diminish a little on the posterior aspect of the

leg, while it projected rather more on either side: in crawling, and in the early attempts to walk, one leg was as useful as the other. The child seemed in perfect health, and was riotous and strong. When he was ten months old, in order to determine the nature of the swelling, a small puncture was made on the inner side of the calf; a quantity of dark-coloured blood first flowed, then there escaped what were apparently lumps and shreds of fibrin, and finally a pretty free arterial stream issued from the wound. A pad and a bandage were applied, and the parents being unwilling that any operation should be resorted to, no further measures were adopted. The puncture greatly diminished the size and tension of the swelling, which, however, shortly regained its former size, and two months afterwards, when the patient was a year old, the left calf measured nine inches and a-half in circumference, while the right was only six inches and a-half; the temperature of the two limbs was alike; there was no tenderness, and no discoloration of the skin; the movements of the limb were unimpaired, and the child was in perfect health. Pulsation could be felt in both the tibial arteries in the right foot, and in the anterior tibial in the left foot, but no pulsation was detected in the left posterior tibial artery. For two months no alteration took place either locally or in the boy's general condition, except that he was learning to walk, and gaining strength rapidly.

In November, 1864, his mother being anxious to have something done for his relief, he was admitted into St. Bartholomew's Hospital, under my care. She stated that the boy had been going on well until fourteen days before, when the swelling began to increase very rapidly, became harder, and seemed to give the child pain; up to that time he had been running about on the leg.

On admission, the left calf measured eleven and a-half inches in circumference; it was very tender, tense, shining, and mottled over with blue veins; in fact, the swelling presented every appearance of medullary disease. There was no enlargement of the inguinal glands. The child was irritable and querulous, his appetite was bad, he was much thinner, his flesh flabby, and his skin pallid: there were aphthæ in the mouth.

Three days after admission, the limb was removed at the knee-joint. The child was discharged in three weeks with a good stump, and much improved in health; but he died, seven weeks after the operation, with symptoms of pulmonary disease, and with numerous cancerous nodules in the subcutaneous tissue, his age at the time of death being seventeen

months. The growth, which involves the soft parts of the limb only, is situated among the deep muscles of the leg. The tibia is seen to be partly absorbed by the pressure the tumour has exerted upon it; its periosteum is, however, uninjured, and the bone free from disease. The growth presents to the naked eye the appearances of soft cancer.

Microscopically the growth is of a cellular nature, being composed of small ill-formed cells, with abundant nuclei.

Among the various hypotheses concerning the origin of cancerous disease, is that which assigns the commencement of the local disease to an alteration of lymph, serum, or blood effused into the tissues as the product of inflammation or the result of an injury.

Without giving preference to this or any other extant hypothesis concerning the origin of cancer, I would place this case on record as one in which the cancerous disease occupied the exact locality of what had been for some months previously an effusion of blood.

But even if the cancer in this case owed its locality to the collection of blood, it may well be doubted whether the cancerous growth had its origin in a degeneration or alteration of the blood elements, or whether the existence of the effusion, by impairing the nutrition of the part, had reduced it (as regards the power of resisting changes in its normal nutrition) to the condition of a "locus minoris resistentiæ."

Mr. Thomas Smith, *2nd of May*, 1865.

---

4. *Lobulated mammary tumour.*

This specimen was taken from the right mammary region of an unmarried woman, æt. 23, a patient in the Great Northern Hospital. It had been six years in growth, and had recently increased with so much rapidity, being now nearly five inches in its long diameter, that Mr. Gay advised its speedy removal.

It commenced at the upper and inner edge of the gland, and grew downwards, so that its lowest point was below that of the gland. It was distinctly lobulated, could be moved freely under the skin, but was attached to the edge of the mamma, so that before its removal it was doubtful whether it was within or without its substance. It caused little pain, and no other inconvenience save that of size. It was easily removed; but for its complete extirpation it was necessary to cut away with it the whole of the inner margin of the gland by which it was overlapped.

The tumour was made up of many and variously sized lobules. It was found to be inextricably associated with the portion of the gland removed, and this, as far as it could be ascertained, by means of its (the mammary) capsule, within the texture of which the cysts themselves had every appearance of having taken their origin and having been developed, for on careful examination of the extreme margin of a firm fibrous membrane which was removed with the growth, there were found other cysts, some of the size of mustard seeds, others larger. These were pointed out by my friend Dr. Hodgkin, who kindly superintended the examination.

The capsule of the tumour was dense, and had compressed its tissue, so that the latter seemed to expand freely when the capsule was divided during the operation.

The lobules were made up of fibrous cysts, which on being opened were found to contain a layer of delicate areolar tissue, sending down equally delicate filaments to the centre, in the meshes of which was embedded a quantity of nucleated cells of all sizes and shapes, free nuclei, and granules, making altogether a tolerably firm compact mass.

In one cyst, however, a different arrangement presented itself, for to its interior was attached a pedicle, on which were suspended several free cysts of different sizes, which nevertheless contained the same elements, and in the same order of arrangement, as the others.

In close contiguity to the mammary gland, and also apparently within its capsule, a small tumour was found differing from the others, in having no *capsule* or cyst that could be discovered, and in its being made up entirely of fibrous stroma. It was, however, easily enucleated.

This tumour does not correspond with the generally accepted views of the structure of mammary tumours. It had none of the elements of the normal gland.

Does it not point to retrograde action in abnormally developed tissue, the *cyst* giving origin to delicate areolar tissue, and this, by a further retrograde step, to cells? The small cysts pointed out by Dr. Hodgkin explain the causes of *recurrence* in such growths; and it is to be feared, as they were so close to the margin of the removed tissues, that some may not have been removed, and may yet develope to the further annoyance of the patient. This suggests the necessity of not being too "conservative" in the removal of the *bordering* tissues, when these tumours have to be removed by operation.

Mr. Gay, 16*th of May*, 1865.

IX. DISEASES, ETC., OF THE DUCTLESS GLANDS.

A. SPLEEN.

1. *Embolism of the spleen and lungs in a case of enteric fever.*

Henry M., æt. 40, was admitted into the London Fever Hospital on the 23rd of August, 1864, and died on September 7th, about the end of the ninth week of an attack of enteric fever. He suffered from diarrhœa all the time he was in Hospital; his tongue was dry, brown, and cracked, and he was greatly emaciated. On August 27th, the respirations were 36, and dry and moist râles could be heard over the back of both lungs. On August 29th, there was slight hæmorrhage from the bowels. On September 7th, he had violent retching, and became extremely prostrate; his breathing was thoracic, and his features sunken; and at 9 P.M. of the same day, he died.

Post-mortem examination.—The body was extremely emaciated; there was no general peritonitis, but the small intestine was brightly injected, and the coils of the ileum were glued together by recent lymph, and particularly at those parts corresponding to Peyer's patches. There were numerous ulcers in the lower two feet and a-half of the ileum. These ulcers showed no tendency to cicatrization; their edges were formed by a loose non-adherent fringe of mucous membrane, and their bases consisted of the denuded muscular fibres, or at many places of nothing more than peritoneum. In the interior part of the spleen were two wedge-shaped yellowish deposits about the size of chestnuts, resembling in every respect those ordinarily ascribed to embolism. On the outer surface of the spleen there was a little recent lymph. The liver contained no abnormal deposits; but both lobes of the left lung were studded with small masses of lobular pneumonia passing into pus, and the lower lobe was coated on its pleural surface with a thin layer of recent lymph. The heart was healthy.

Remarks.—Pathologists who believe in the existence of a peculiar "typhous deposit" have described the spleen as one of its seats; but the only deposits that I have met with in the spleen in the course of enteric fever have corresponded in every respect with those now described, and have exactly resembled those ordinarily ascribed to embolism. The concurrence in this case of that form of pneumonia which is apt to be developed in cases of pyæmia is of peculiar interest. In the Fifteenth Volume of the Pathological *Transactions* (p. 132), I have re-

corded a case of enteric fever, where the liver contained a deposit which was believed to result from embolism. It is to be noted that the existence of peritonitis in this case was independent of actual perforation.

Dr. Murchison, *4th of April*, 1865.

B. SUPRA-RENAL CAPSULES.

2. *Case of Addison's disease.*

This case was almost a typical example of the disease. The patient was a widow, æt. 40, a straw-plaiter. She was admitted into St. George's Hospital, on the 11th of May, 1864, under the care of Dr. Pitman. Twelve months before, she had left her occupation from want of strength to continue it. Last summer she first noticed that her skin was getting brown, and was told by friends that the liver was at fault. She had not kept her bed, but had wasted considerably, and had repeated vomiting of mucus and clear water. Mere debility was, however, the most prominent symptom. When admitted, she had been ill in this way for eighteen months. The patient had been exposed to privation through poverty.

When admitted, there was a very general bronzing of the skin; the face, the back of the neck and of the hands, and, most of all, the thighs were the darkest parts. The tips of the fingers were natural. The woman was so dark that no person entering the ward could possibly fail to be struck by her appearance. Her hair was short, black, and curly, giving an Asiatic appearance to the face; she said that last winter her hair, which was then dark brown, had fallen off, and had been succeeded by what she had when examined. There was some hair on the upper lip and chin. The woman's manner was listless and free from anxiety, the pulse was small and very weak, the respiration was very feeble, the tongue was clean, the bowels regular. Though the skin was cool, complaint was made of burning heat. She stated that she never sweated. The breath had a sickly smell. The urine was abundant and natural. The patient died five days after her admission; during this time retching and vomiting were frequent, and there was great prostration. On the morning of her death she became slightly convulsed, and from that time she lay in a semi-comatose state, with open eyes, vomiting occasionally, or making the attempt to do so. Hiccough came on before death, and the skin became clammy. The preceding account is from Dr. Sturges's notes.

The *post-mortem* examination was made twenty-one hours after death. The body appeared emaciated, though on cutting into it a considerable quantity of subcutaneous fat was found. The skin was generally bronzed to the tint of a mulatto, though the shade presented some variety. The lower parts of the buttocks were darker than any other part; next came the upper parts of the thighs, close to the groin. There was a dark patch also just above each patella; the face was darker than the shoulders, the colours shading off after the manner of a sun-burn. The darker parts were almost like the skin of a negro, though of a browner shade; some places had retained their natural pale colour. The hair was very dark brown, short and curly, but fine; there were indications of beard, whiskers, and moustache of the same colour, consisting of short dark hairs tolerably closely set; the eyes were of a light grey colour.

A thin section of the discoloured skin displayed the following characters:—The true skin was perfectly natural and colourless. The layer of epithelial cells in contact with the papillæ was deeply charged with yellowish brown pigment, while the more superficial parts of the cuticle were perfectly colourless: on section it was evident that the colour was limited to a single row of epithelial cells, and that the deepest. The row of cells lying next to this was perfectly free from colour; the appearances were exactly such as have been represented by Mr. Hutchinson, in the Eighth Volume of the *Transactions*. For the purpose of comparison, similar sections were made from the skin of a Hindoo which was coloured to about the same tint. A great difference was found in the disposal of the pigment, which, instead of being limited to the deepest layer of cells, was diffused through the whole cuticle. The deeper cells were indeed darker than the more superficial, but there was no demarcation. The colour gradually lessened on approaching the surface. The difference was so decided that it would have been easy to say from the microscopic appearances whether the specimen was the result of disease or climate.

The supra-renal capsules were diseased; the left was adherent to the pancreas, and on separating it a small quantity of pus escaped from the point of junction. The organ itself was much increased in size; it weighed six drachms; it was nodular, extremely firm in texture, and of a light buff colour. On section, it was found to consist of two distinct materials; the outer part was of a buff colour, firm, close, and elastic, with a sort of marbling upon the cut surface, and more like a fibro-plastic tumour than anything else. The centre of this was replaced

by a deposit of soft yellowish opaque matter not unlike crude tubercle.

Microscopically, the outer part was found to consist of an aggregation of cells, of large size and various shapes. Some were spindle-shaped, some like spear-heads, and others had a variety of angular and rounded forms. Most of them contained a single large nucleus. The central white part contained loose oil-globules and imperfectly formed pus.

The same description applies in all respects to the right supra-renal body, excepting that it was smaller, weighing only two drachms, and was not adherent to any neighbouring organ. The white centre was semi-fluid in places where it had the character of pus.

Several small greyish nodules of the size of millet seeds were detected under the peritoneum in many places, particularly upon the bowels and mesentery. These looked like miliary tubercles, but under the microscope were found to consist of a cellular formation like that in the outer portions of the supra-renal bodies. The same sketch would serve for both.

The lung contained a few crude tubercles. There was a small mass of this sort at the apex of the right lung, and on the surface of both organs were several round masses as large as peas, which consisted of a black, intermixed with a buff, material. These were believed to be crude tubercles which had acquired a partially black colour. Under the microscope the black matter was found to be divided into fine granules. It was unaffected by nitric acid, was perfectly black, and was apparently carbonaceous.

The Fallopian tubes were both adherent to the ovaries, and were distended with thick creamy pus, probably tubercular.

The mitral valve was thickened; both ventricles of the heart were uncontracted.

All the organs which have not been mentioned were natural.

Remarks.—This case altogether is most characteristic.

The supra-renal disease was clearly diagnosed during life. It is not necessary, in the present state of our knowledge, to insist upon the connection between supra-renal disease and bronzing of the skin; probably no member of this Society will dispute the fact.

As to the peculiarity of the skin which has been described, it may be suggested that the limitation of the pigment to the lowest layer of epithelial cells may be due to the recent origin of the colour. The

cells coloured were those of latest growth. A considerable time must be needed for the inner layer of cells to become superficial, so as to carry the colour through the whole thickness of the cuticle, as is the case in coloured races of men.

The disease which affected the supra-renal capsules appears to be something *sui-generis*. The entire capsules were involved; the outer portion, which was cellular, bore more relation to a fibro-cellular tumour than to any other form of disease, though the cells were more various in shape than is the case with such growths. The central soft part was probably the result of a degenerative change. The fact that small deposits of the same kind as had destroyed the capsules were attached to the peritoneum seems to suggest a constitutional origin to the disease. Dr. Dickinson, 6*th of December*, 1864.

---

3. *Tumour of supra-renal capsule.*

This specimen was taken from the body of a woman, æt. 72, who died in the Middlesex Hospital, on the 7th of December, 1864, of chronic bronchitis. There was no discoloration of the skin, aor any symptom during life to indicate disease of the supra-renal capsules.

Projecting from the anterior surface of the right supra-renal capsule is a tumour the size of a small walnut. In front and behind it, a small portion of the capsule is of normal appearance. The surface of the tumour is of a yellow colour, nearly smooth, and differs but little in appearance from the rest of the cortex. The tumour also forms a slight projection on the posterior aspect of the capsule. On section through the capsule, the anterior and posterior portions appear quite normal. The substance of the tumour is of a deep yellow colour, moderately firm, and nearly homogeneous: it is continuous with the normal portion of the cortex, from which it only differs, by being firmer and more homogeneous. It extends through the whole thickness of the capsule, and the medullary substance is interrupted by it.

On microscopical examination, the tumour was found to consist almost entirely of oil globules, arranged in tube-like spaces resembling those of the normal capsule. Cells containing pigment granules were also visible. The weight of the capsule was four drachms. There was no thickening of the fibrous investment of the capsule, nor adhesions to neighbouring organs.

I have not been able to find any record of a similar condition, which

may perhaps be looked upon as hypertrophy, with fatty degeneration, of part of the cortex. The other capsule was normal.

Dr. Cayley, *20th of December*, 1864.

---

4. *Case of Addison's disease of the supra-renal capsules.*

E. W., æt. $12\frac{3}{4}$, was admitted an out-patient of the Middlesex Hospital, under my care, on the 20th of January, 1865. She had suffered from bronchitis in July, 1864, on recovery from which she had been sent into the country, where she was much in the open air, and on her return home, apparently quite well, after an absence of six weeks, her parents remarked that she looked sunburnt. This slight duskiness of complexion, which was limited to the face, neck, and hands, never left her, but she continued without any definite symptoms of illness until a few days before she was brought to the Hospital, although her father had considered her as "drooping" during the three or four previous weeks. On Sunday, the 15th of January, she was sick for the first time, but continued to attend school until Wednesday the 18th, on which morning she was sick again, and complained of feeling cold. Her mother administered a strong cathartic powder, which was followed by copious purging and vomiting, and from that time intense depression set in. When brought to the Hospital she was scarcely able to move, had an extremely languid, listless, exhausted aspect, a pallid countenance, and a remarkably small, feeble pulse. Her breathing was frequently interrupted by sighing and yawning, and the slightest attempt at exertion caused her to retch. The eyes were large and prominent, and the conjunctivæ peculiarly white. The skin was cool, the tongue clean and moist; there was no cough nor diarrhœa; and no other disease being discoverable to account for her extremely asthenic condition, I immediately diagnosed the case as a true example of Addison's disease. The patient not wishing at that time to come into the Hospital, I continued to watch her at home for several days, during which she slightly rallied, the sickness abated, and she was able to take and retain food. On the 22nd, she began to cough, and expectorated a small quantity of glairy mucus tinged with blood; the vomiting presently returned in its former severity, and she was admitted into the Hospital on the 26th of January.

On examination after admission, the duskiness of her face, neck, and hands, although still by no means very marked, was more evident than

it had been in the out-patient room, and a slight duskiness was now observable on the abdomen, and about the knees and axillæ; the nipples also appeared slightly dark. On examining the mouth carefully, I detected a single dark stain, of the size of a large pin's-head, upon the buccal mucous membrane lining the right cheek, but no definite patch or stain was found anywhere else, and the amount of discoloration was, in my opinion, insufficient even to confirm the diagnosis I had made from the constitutional symptoms. There was slight dulness on percussion, and bronchial breathing below both clavicles; but the patient had scarcely any cough, and no expectoration, after her admission into the Hospital. The asthenia, however, increased; she always vomited soon after taking food, and retching, faintness, and failure of the pulse came on whenever she was moved. She scarcely slept at all in the Hospital, became very restless on the 27th, and died, rather suddenly, on the evening of the 28th of January, retaining her consciousness to the last.

Post-mortem examination.—No signs of puberty; mammæ undeveloped. Hair dark brown; complexion of face uniformly dusky. The neck was darker than the face, and presented a distinct contrast to the colour of the chest, which was natural. The areolæ were slightly dark; the axillæ, abodomen, thighs and knees dusky, but the legs and feet perfectly natural in colour. There were no dark moles, nor other definite patches of discoloration, and the general aspect was that of a person with a naturally dark skin, but with a fair chest, feet, and legs. There was a moderate amount of fat underneath the skin of the thorax and abdomen; the muscles were firm and red. There were firm fibrous adhesions at the apices of both lungs, and some small pigment patches on the surfaces of the pulmonary pleuræ. The apices of both lungs were puckered on the surface, and consolidated by the deposition of tubercle, chiefly of the grey, semi-transparent kind; there were no cavities; but in the right lung, at one or two points, the tubercle was beginning to soften. There were also two or three small masses of grey tubercle in the lower portions of both lungs. Nearly colourless clots of moderately firm consistence were found in all the cavities of the heart, adhering to the musculi pectinati and chordæ tendineæ, and extending into the great vessels. In the stomach near the pylorus, were a few small reddish patches of congestion, the rest of the mucous membrane being pale and normal, as was that of the upper part of the intestines. In the lower part of the ileum, Peyer's glands were more than usually prominent, and the mucous membrane was somewhat congested; the solitary glands were enlarged, and here and there one was opaque and slightly yellow. The mesenteric glands

were a little enlarged, but appeared otherwise normal. The kidneys were of moderate size, and somewhat hyperæmic.

The supra-renal capsules were both much enlarged. The fibrous envelope of the right capsule was much thickened, and firmly adherent to the kidney, liver, and diaphragm. The organ itself was hard and somewhat nodulated, and when cut across no trace of the normal structure was visible, nor any distinction between cortex and medulla. It was chiefly made up of masses of opaque yellow matter, partly of cheesy consistence and partly friable, with here and there some gritty matter; in addition to these, and in part separating them, was a greyish semi-transparent tissue of tough consistence. In the upper part of the organ, beneath the thickened fibrous capsule, was a collection of puriform fluid. The left supra-renal capsule also had its fibrous envelope thickened and adherent to the kidney and diaphragm. It was somewhat softer than the right one, but, like it, was nodulated. On section, it showed no distinction of cortex and medulla, nor any trace of normal structure, but was composed of opaque yellow deposits resembling those of the right capsule, but of smaller size, and separated from each other in the same manner by the greyish semi-transparent tissue, which was much more abundant in the left than in the right capsule.

Dr. Burdon Sanderson has favoured me with the following notes of a microscopical examination of the left supra-renal capsule, made by him at my request. (*See* Plate VII. B.)

The capsule, which is still attached to the kidney, is of the size and shape of a walnut. It is closely invested with a covering of dense fibrous tissue, about half an inch in thickness, which is in some parts separable from the external surface of the organ, in others firmly adherent, and, as it were, incorporated with it.

In the section of the organ no distinction can be made out between rind and kernel; but it exhibits several varieties of structure and consistence without definite arrangement. Some parts are of a pinkish colour, somewhat translucent, and of firm consistence; others are white, soft, of a consistence approaching to cream-cheese, and occasionally gritty. Between these there are various gradations; thus in many parts the tissue has lost its translucency and colour, but not its consistence. Between the translucent parts and the opaque parts there is a great difference in structure, as shown under the microscope. The former exhibit (even without the addition of acetic acid, and much more distinctly after the addition of that re-agent) nuclei (Fig. *a*) which are

embedded in a finely granular stroma. The granular appearance is owing partly to albuminous granules (which disappear with acetic acid), partly to fat-granules. These nuclei are usually oval or round; but in some parts they are elongated, in a definite direction, into spindle-shaped bodies or nuclear fibres (Figs. *b* and *c*), as shown in the accompanying sketch. The opaque portions exhibit no nuclei or cell structures, either with or without acetic acid. They exhibit, in fact, only albuminous, fatty granules, the latter being more abundant in proportion to the advance of the process of softening. No structure having any resemblance to tubercle is to be found. It is tolerably evident that the change consists (1) in the development in the organ of the firm tissue, of which the structure is above described, viz., an albuminous exudation undergoing gradual transformation into fibrous tissue, and (2) of the fatty degeneration of this substance. Dr. Greenhow, 7*th of February*, 1865.

---

5. *Cancer of right supra-renal capsule.*

This case was that of a woman, æt. 45, who died in the Middlesex Hospital of medullary cancer of the uterus, with secondary deposits in the peritoneum, the liver, kidneys, lumbar and mesenteric glands. In the substance of the right supra-renal capsule, was a nodule of medullary cancer the size of a large pea; it projected from the surface, and did not invade the medullary part of the organ.

The colour of the skin was remarkably dusky and sallow, especially in the face and neck. It had been noticed during life that in the last month the patient had been getting much darker. The areolæ round the nipples and the folds of the axillæ and groins were not darker than usual, and there were no dark patches on the skin anywhere. The body was extremely emaciated. The symptoms of cancer of the uterus began about a year before death. Dr. Cayley, 18*th of April*, 1865.

---

6. *Unusually large mass of carcinomatous deposit in one of the supra-renal capsules of a child.*

The patient, Sarah W., æt. 3, a resident of Chelsea, near the river, was brought as an out-patient to St. George's Hospital, in September, 1864. She was unusually stout, weighing forty-four pounds, her height being two feet ten inches and a-half, and her girth across the abdomen being two feet three inches. She had a peculiar, sullen look, very marked features, and there was a very unusual amount of hair over the whole body. Thus the eyebrows were excessively large, thick, and

bushy, and a decided moustache existed on the upper lip, also a very large amount of curly hair on the genital organs, which were large and well developed.

The colour of the whole of the skin was remarkable, being of a gipsey, coppery hue, but nowhere at all of that colour termed "bronzed."

Her mother, of dark complexion, but otherwise of ordinary appearance, had four other children, none of whom were affected like the present one. She herself had had an epileptic attack when pregnant with this child. After birth the child had been quite healthy and well-developed, with a somewhat dark skin, until eight months previous to her coming to the Hospital, at which time she had some affection of the chest which was termed "inflammation." Since that period, she had been progressively increasing in bulk. Her mother said she had got "*her mouth full of teeth.*" She was very silent, and but little impression could be made upon her. She had never had anything like ague; but had a hard swelling of considerable size on the left side below the lower ribs, which had only just been noticed. This did not appear to be tender on pressure, or to give pain in any way. I put her under the use of small doses of the iodide of potassium, and with this she continued for a month, at the end of which time she was brought into the Hospital as an in-patient, under Dr. Pitman's care, owing to constant vomiting which she had had for two or three days. She was extremely exhausted, and could keep no food on her stomach. She died on the day after admission into the Hospital.

Post-mortem examination.—The external appearances of the body were such as have been described above. The whole of the organs of the body (including the internal generative organs, &c.) were in a perfectly normal condition, excepting the left supra-renal capsule, which was the seat of a large mass of encephaloid cancerous growth, weighing no less than two pounds two ounces, and the liver, in which was a mass of carcinoma of the size of a chestnut. The adjoining kidneys were quite healthy, as also the lymphatic glands within the abdomen.

Microscopical examination.—The carcinomatous masses (as much connected with the liver as the supra-renal capsules) were composed of much granular fat, and multitudes of round and oval nucleated cells undergoing, for the most part, fatty alteration.*

Dr. John W. Ogle, 18*th of April*, 1865.

Report on the above Specimen.—We believe the tumour to be cancer-

* See Hospital Post-mortem Book, 1864, No. 280.

ous degeneration of the left supra-renal capsule, for the following reasons:—

1. Because though a supra-renal capsule existed on the right side, none could be found on the left, though diligently sought for, and because the absence of a supra-renal capsule is very rare, and when it does occur it is found to be associated with a deficiency of other organs.

2. That cases have been reported of cancerous degeneration of the supra-renal capsule.

3. That the anatomical relations of the tumour to the left kidney are similar to those of the supra-renal capsule.

4. That a vein, apparently emerging from the cancerous mass, opened into the upper part of the left emulgent vein, and that we know of no vein communicating from above with the emulgent vein except the supra-renal vein, though occasionally a vein from the adipose capsule of the kidney opens into it, and there is sometimes a communication between the left renal vein and the superior mesenteric veins.

5. That the tumour is too much circumscribed to be a mass of cancerous absorbent glands, and that the absorbent glands in the neighbourhood were in a healthy condition.

Mr. Richard Partridge,
Dr. W. H. Dickinson,
Dr. John W. Ogle,
Mr. George W. Callender, 16*th of May*, 1865.

---

7. *Cyst, with semi-transparent parietes, occupying about a quarter of one of the supra-renal capsules.*

The patient, Peter O'H, æt. 61, was admitted into St. George's Hospital on the 21st of September, 1857, having sustained injury to the back, and fracture of certain costal cartilages and of a radius, owing to a backward fall on the ground. Paralysis of motion of all the limbs came on, with *dilatation of one pupil.* Delirium preceded death, which occurred on the 29th of September. There was no unnatural appearance of the skin. After death the lower part of the cervical region of the spinal cord was found to be softened and to contain spots of ecchymosed blood.

The various abdominal organs were healthy, excepting the left supra-renal capsule, in which was a cyst of about the size of a boy's marble, having almost transparent parietes, and containing turbid serum. The substance of the supra-renal capsule otherwise appeared to be healthy. Dr. John W. Ogle, 17*th of May*, 1865.

C. THYROID GLAND.

8. *Cancer of thyroid gland, causing pressure on the trachea.*

Mr. Henry Smith exhibited a specimen of what he supposed to be cancer of the thyroid gland, taken from a man, æt. 50, who had been received into King's College Hospital with urgent dyspnœa, for which the operation of tracheotomy was performed, and soon followed by death. Difficulty of breathing had been felt by the patient for about three months, but the more urgent symptoms had only come on very recently.

On *post-mortem* examination, the larynx and trachea were found embedded in a mass of diseased tissue apparently connected with the thyroid gland, and on section this tissue presented all the characters of scirrhus. There was no similar deposit found in any other organ of the body. Mr. Smith considered that the case might be called cancer of the thyroid gland, a very rare disease, but of which one or two instances had already been reported.

Mr. Henry Smith, 18*th of October*, 1864.

Report on the above Specimen.—The trachea is enveloped in front and laterally by a mass of dense tissue, at some places about two inches in thickness. This mass extends downwards to within an inch of the bifurcation of the trachea, and upwards in front of the thyroid gland, especially over the right lobe. The left lobe of the thyroid is also covered by a thin layer of the morbid tissue; but the whole of this lobe can be dissected out and separated from the tumour without any difficulty. On microscopic examination also of this lobe nothing abnormal can be discovered. The tumour, however, is firmly adherent to the right lobe and to the lower part of the isthmus of the thyroid. The morbid tissue yields at many places a creamy juice containing numerous cells, with one or more large nuclei, and presenting the appearances of the cells ordinarily met with in cancer. Several of the lymphatic glands in the neighbourhood of the tumour are as large as filberts or cherries, and contain cells like those found in the tumour itself.

From an examination of the specimen, we are of opinion that the tumour is of a cancerous nature, but that the disease commenced externally to the thyroid gland, and only encroached upon it secondarily.

Dr. Murchison,

Dr. George Harley, 1*st of November*, 1864.

X.—DISEASES, ETC., OF THE SKIN.

1. *A photograph, coloured from life, of psoriasis diffusa and guttata, affecting the skin over the knees, following a fall.*

The photograph was taken from a girl, æt. 16, on whom the disease first appeared when she was two years old, since which time it has never left her. It came first on the elbows, spreading thence down the outer side of the fore-arms. At the age of six she fell under a grating, and grazed both knees. Shortly after this the disease appeared for the first time on the knees.

Her present state is as follows :—Her head, face, and neck are perfectly free from the disease. Extending from either elbow, half-way along the outer aspect of the fore-arm, is a large patch of psoriasis diffusa. On the arms and fore-arms are several spots of psoriasis guttata ; these are more numerous on the outer than on the inner sides of the limbs. On the back, but chiefly about the loins and on the upper half of the outer aspect of the thighs, are many larger guttate patches. The anterior aspect of the trunk is entirely free, with the exception of one or two small spots under the clavicles.

On the front of the right leg, but more on its outer than on its inner surface, is a large patch of psoriasis diffusa, which extends from the upper margin of the patella, nearly half-way to the ankle. On the front of the left leg are two large patches of psoriasis guttata. These are excellent specimens of the sub-variety termed psoriasis nummulata ; they are both situated within the boundaries of the portion of skin that corresponds to the large patch on the right leg. On the dorsum of either foot, midway between the bend of the ankle and the ends of the toes, but nearer to the outer than the inner margin of the foot, is a small patch of psoriasis nummulata.

The exhibitor, after alluding to the well known predilection of the disease for the elbows and knees, remarked that in this case the eruption, after remaining confined to the neighbourhood of the elbows for four years, appeared for the first time over the knees, shortly after mechanical injury of the skin there. He had frequently noticed, in cases of constitutional disease of the skin, that mechanical or chemical injury of a sound portion of the integument, especially in any region where the disease was prone to occur, would often determine its appearance there.

In noticing the propensity of the disease to attack the dorsal rather than the abdominal surface of the body, he observed that in this case the loins were more affected than any other part of the trunk. This he had remarked to be *the rule* in cases of psoriasis. He had found a knowledge of this partiality of the disease for the lumbar region a useful aid in diagnosis. So far as he was aware, it had not been noticed by any other writer.

He called attention to the *tawny* red colour of the skin underneath the scaly patches, where the latter had been partially removed by the scratching of the patient, since a tawny redness of the skin was often thought to be a sure indication of the *syphilitic* nature of an eruption. His own experience was decidedly opposed to this assumption. He considered the opaque white glistening squamous incrustation portrayed in the photograph, and the situation of the disease over the elbows, knees, and *loins*, to be much more reliable as means of distinguishing simple from syphilitic psoriasis; indeed, in no case of simple psoriasis that he had yet met with, had the tawny tint of the inflamed skin been wanting.

Mr. Balmanno Squire, 18*th of October*, 1864.

---

2. *A photograph, coloured from life, of impetigo figurata, affecting the skin of the forehead and nose.*

The portrait was that of a boy, æt. 4, in whom the disease first appeared when he was two years old. On this occasion, by his mother's account, it had lasted (under treatment) three months, and had occupied the forehead, eyebrows, and chin. When he came under the author's care, the disease had lasted four months; this was the second time it had appeared. It began on the forehead, spreading downwards to the nose and cheeks. All the rest of his skin was perfectly free from disease.

The exhibitor especially directed attention to the *lakish* hue of the inflamed portion of skin, where this extended beyond the limits of the crust, and so became visible on the left cheek, as also at the upper part of the patch on the forehead. He contrasted it with the *tawny* hue of the inflamed skin represented in the photograph of the case of psoriasis. This *lakish tinge* was present in all the diseases of the skin that were referrible to the scrofulous diathesis, and was a distinguishing feature of them. The photographic portrait was, as the features showed, evidently that of a boy of scrofulous or lymphatic constitution.

The exhibitor further directed attention to the evidently considerable

thickness of the crusts that had formed over the inflamed skin, and to the greenish tone, in places, of the brown-yellow crusts. These were more important means of distinguishing the disease from eczema, than vesicles or pustules; since when either of these diseases came under medical observation, in the majority of cases neither vesicles nor pustules were any longer to be seen.

Mr. Balmanno Squire, 18*th of October*, 1864.

---

3. *Case of favus cured without epilation.*

A. S., æt. 13, came under my care on the 14th of July, 1864. He was a pale, pasty boy, with blue eyes and light hair, a sluggish iris, and a thick upper lip. He had been affected with favus for three years. During the whole of this time he had been constantly under treatment of various kinds. The eruption appeared first over the occiput. In the course of about twelve months it had spread itself over every part of the scalp. He is in the habit of assisting his father, who is a cabman. I mention this on account of what has been said as to the connection of this disease with the occupation of grooming horses. The family to which he belonged barely earned a livelihood for themselves, their dwelling was unusually squalid and dirty, even for people of their class, and they rarely tasted animal food. I refer to this, since all the cases of favus that I have seen (about half-a-dozen) have occurred in persons of the very poorest class.

The disease, at the time the boy first came under my notice, occupied the whole of the hairy scalp, but ceased abruptly at the margin of the scalp. No vestige of it was to be discovered on any other part of the body. Towards the anterior margin of the scalp, it presented the condition known as favus lupinosus. But over the greater part of the scalp it had arrived at the stage recognized under the name of favus squarrosus.

The head swarmed with pediculi, and exhaled the peculiar fetid, mouse-like odour characteristic of the disease. On examination, under the microscope, of a detached favus-cup, it was found to consist of (*a*) epithelium cells, (*b*) an amorphous homogeneous finely granular stroma, (*c*) narrow sinuous ramified tubules containing molecular granules (the *mycelium*), (*d*) broader (*sporoforous*) *tubules* containing, some, minute rounded cells, others, elongated cells placed end to end and

giving the tubules a jointed appearance; (*e*) spores, some of them free, others joined end to end like a string of beads. The stroma and mycelium were found in greatest abundance towards the lower (convex) surface of the favus-cup, while towards its concavity the cup consisted chiefly of sporules.

On examination of the hairs of the head, none of which exceeded half-an-inch in length, the filaments and spores of the Achorion Schönleinii were seen in the substance of the stem and of the knob of the hair, as well as in its root-sheath.

The object I endeavoured to effect by the mode of treatment I devised, was the doing away with the process of epilation which is invariably employed in the treatment of favus at the Hôpital St. Louis, in Paris, where the disease is still commonly met with, notwithstanding its great rarity in this country. My objections to epilation were, that, notwithstanding what is alleged to the contrary, it is often a painful process, and, moreover, that it can never be perfectly performed, and if imperfect is useless; further, that the inunction of ointments containing insoluble powders, such as are used after epilation, can have no effect on those portions of the parasite that are within the hair follicles. *The* desideratum I imagined to be a fluid medium containing a substance (noxious to lower vegetable life) soluble in it, which medium should not readily evaporate, or, on the other hand, become solid,—should be such as would completely exclude air from the vegetable growth, and so tend to check its development,—and should be of a kind best calculated to mix with the secretion contained in the hair follicles, so that by osmotic action it might permeate them thoroughly. I saw at once that all these conditions would be fulfilled by a solution of sulphur in olive or in almond oil, provided it were possible to make such a solution. I found that, by the aid of a gentle heat, olive oil could be made to take up a considerable proportion of sulphur, and that, at ordinary temperatures, a fluid ounce would hold in solution about six grains. The application of this, after a thorough poulticing, was the only local treatment employed. Internally, cod-liver oil and steel were taken. His scalp is now (six months after commencement of treatment) thickly covered with healthy hair, of an average length of three inches and a-half, and shows no trace of the disease. A photograph of the disease before treatment was exhibited. Mr. Balmanno Squire, *3rd of January*, 1865.

4. *A coloured photograph from life of lichen inveteratus.*

The photograph shown represented a view of the shoulders of a woman, æt. 45, who had been the subject of lichenous disease of the skin for sixteen years. At the time she was photographed, the disease covered the whole of the posterior surface of the neck as well as of the upper third of the trunk. It extended upwards to the margin of the hairy scalp, while between the scalp and the level of the shoulder-joints, its limit on either side corresponded to the outer margins of the trapezius muscle, and thence to the level of the scapular angles; its lateral margin corresponded with the position of the teres major muscle on either side. Inferiorly, on either side, the disease was limited by "the angles" of the scapulæ; in the middle line, however, it did not extend so far downwards by an inch or two.

All the rest of the patient's skin was perfectly free from disease of any kind, nor has any other part of the surface besides that now occupied by the disease ever been affected by it.

The exhibitor drew attention to the unusually large size of the lichenous patch. It was not uncommon to see the greater part of the surface in children attacked with lichen at one and the same time, but it was rare to find a chronic patch in an adult that had attained such dimensions as this had. The duration of the patch, although prolonged beyond the usual limits, was not longer than was often noted. However, what he more particularly wished to draw attention to was the entire absence of papules in the disease, since it was very generally thought that lichen was to be recognized and distinguished from other diseases of the skin by the presence of a number of minute acuminated reddened papules closely clustered together. So far from these being the best means of recognizing and distinguishing lichen, in a very large proportion of the cases of lichen at the time they come under medical observation, any papules that might once have existed had altogether disappeared. A much more decisive test of lichen was a condition of the skin, the visual characters of which were well portrayed in the photograph shown. This condition was characterized by a very dry and harsh state of the skin, as felt by passing the hand over it. It was usually something more than harsh; it was rough, and in long-continued and severe cases, such as the one under notice, it communicated something of the sensation that would be produced if the hand were passed lightly over a rasp.

Again, if a piece of the diseased skin were pinched up between the finger and thumb, it might be felt that considerable plastic exudation into its substance had taken place, that it was both thickened and indurated; and on examining it carefully with a lens, it would be seen that its surface was subdivided by a number of minute furrows or fissures, which, decussating obliquely with one another, cut the skin into a number of minute fusiform islets; the arrangement of these fissures very much resembled that of the lines in what was called by artists 'cross-hatching.'

Mr. Balmanno Squire, 15*th of November*, 1864.

---

5. *A coloured photograph from life of the hand of a woman affected with scabies.*

The photograph represents the ordinary characters of scabies in a well-marked form. One object in bringing forward the case is to insist on the diagnostic importance of the little curved lines corresponding to the tunnels made by the female acarus in the substance of the skin. Another object I have in view in bringing forward this case is to draw attention to a point of diagnosis between scabies and eczema of the hand, which I believe I have been the first to discover—at least I can find no mention of it in any works on the subject of skin disease, English or foreign. In the illustration it is seen that the sides of the fingers and the inter-digital webs are affected by the vesicular eruption. Out of many hundreds of cases of scabies that I have carefully examined, having proved the diagnosis of each by extracting an acarus from the affected person, I have met with none in which any vesicles have been present on the last phalanges of the fingers. In the majority of cases, the vesicular eruption has not extended further than the first phalanges, and in *none* beyond the second; in all the cases, except a very few, the *dorsal* aspects of the fingers have been quite free from vesicles, and in all, without exception, the eruption has been by far more copious on their lateral than on the dorsal surfaces.

On the other hand, in cases of eczema of the hands, I have always found the dorsal aspects of the fingers more affected than their sides, and in the majority of cases the dorsal aspects alone affected. In a large proportion of cases, the last phalanges of the fingers *were* affected (on their dorsal aspect). In a large number of cases too, the (metacarpo-phalangeal) knuckles were affected; in the photograph of

scabies it will be noticed that these are free from eruption, and I have found this to be the rule in cases of scabies. A case of acute eczema of the hands so much resembles a case of scabies, that is to say, it comes under notice as a recent attack affecting the hands and in the form of blebs of the same size (quite as large) as the blebs in scabies, that in the majority of instances it is at once put down as a case of scabies and treated accordingly. But in their etiology, course, nature (absence of contagious property), and appropriate treatment, these cases differ as widely from scabies as any eruption can. I have therefore thought my discovery, if I may give it such a name, of the well marked diagnostic signs described above, worth while bringing under the notice of the Society.

Mr. Balmanno Squire, *15th of November*, 1864.

---

6. *Sequel to a case of true keloid.*

Mr. Sedgwick exhibited the patient, whose case was brought before the notice of the Society on October 16th, 1860, and recorded in the 12th volume of its *Transactions* (page 234).

It was remarked that the improvement in general health, referred to in the appendix to the former report, had not only been fully maintained, but that the disease itself had almost entirely disappeared. There had not been for the last eighteen months any trace remaining of the horny plates which had once formed the centre of each fully developed patch in this so-called keloid disease; and with the exception of three faintly circumscribed and brownish marks on the skin of the hind part of the body, below the right shoulder blade, and an almost imperceptible mark in front below the right ribs, none of the fourteen patches referred to in the former report could any longer be seen; and the skin might have been pronounced free from the disease, were it not that a small, white, and glossy patch, well known to those who had watched the case as the first appearance of the disease, had been observed within the last five or six weeks on the skin of the neck near the right shoulder: this patch had increased slowly in size, without, however, having undergone any of those subsequent changes in colour and texture, which had characterized the disease in its fully developed state.* It was also

* This mark has since entirely disappeared (June, 1865).

to be noticed, with reference to the occurrence of the disease on a mucous membrane, that a shallow groove or depression along the right side of the tongue marked the situation of what had formerly been admitted to be a well-defined patch of the disease.

With regard to the causes that might be supposed to have led to the child's recovery, it was to be noted that the tendency to a general disappearance of the disease had commenced soon after the date of the last report in March, 1861, when the little patient, having continued for a long time to take cod-liver oil, iron, and quinine, had been enabled to live a more out-of-door life. But it was not, perhaps, allowable to assume much credit for the treatment pursued in such a case, as the favourable result appeared to have been in some measure at least due to the curative influence of time; and this supposition was strengthened by the fact that a corresponding result, so far as referred to what might be termed a spontaneous disappearance of the disease, had followed in a case described, but not named, by Dr. Alderson, in the thirty-seventh volume of the *Medico-Chirurgical Transactions*, in which the account of the disease essentially agreed with the present case, in the characteristic appearance of the patches, in the absence of any local pain or tenderness, and in the spontaneous disappearance of the disease. Whether in Dr. Alderson's case a white patch or opacity of the integument preceded the development of the horny plates, had not been stated; but it had always occurred in the case under notice, and had also been described by Dr. Addison as the first appearance in true keloid.

In conclusion, Mr. Sedgwick called attention to the confusion which prevailed respecting both the name and the nature of these and other allied affections of the skin, and stated that he was almost disposed to follow the example of Dr. Alderson, who, in publishing a case of the same kind, had refrained from assigning to it a name.

Mr. Sedgwick, *6th of December*, 1864.

---

7. *A rare form of skin disease :—keloid or molluscum.*

The patient was a child, aged two and a-half years, who presented over the left eyebrow, between the eyebrow and the eyelid, a hard round tumour, of the size of a large pea, of a red colour, and discharging a small quantity of sero-purulent fluid at its summit. This tumour had existed for six months. On the chest, on the left side of the sternum near the clavicle, was a hard tumour of the size of a small pea, and of

the same colour as the skin; this tumour had existed two years, indeed since the child was six months old. On the forehead there were two or three other hard tumours, of about the size of a millet-seed, not painful to the touch. These tumours appeared to correspond in many respects to the keloid or cancroid tumours described by Alibert, although his description was so vague that it was difficult to give an exact definition of what was meant by authors in writing of keloid tumours; for some represented them as projecting, globular, or oval masses, while others regarded them as resembling the scars of a burn. If the tumours were not keloid in the child now produced for inspection, they belonged to the equally rare disease, molluscum.

Dr. Semple, *7th of March*, 1865.

---

8. *Case of true leprosy. A portrait of face, and wax model of arm.*

J. F., æt. 58, a native of Limerick, in Ireland. His father and grandfather were very strong healthy men, and lived to a good old age. He knew nothing of the other members of his family. He had spent seventeen years in India as an engineer; he returned home two years before he came under my notice. Whilst in India he usually lived in a very damp quarter of Bombay. He had always enough to eat, and his provisions were wholesome; he did not eat much fish; at one period of his life he drank freely. His general health had been good. About eighteen years ago he had venereal disease, for which he was treated with pills, which made his mouth sore. He had a depressed scar on the penis, not indurated; this, he asserted, was the result of disease contracted eighteen years before.

Soon after his return from India, an eruption appeared on his skin. He first noticed pimples, nearly of the normal skin colour, on his arms, legs, and thighs. Their size was about that of pins' heads, and they were unattended with itching, or any unusual sensation. They had since increased in size and number, whilst some, he thought, had disappeared. He had felt for several months very low-spirited and unusually weak. All sexual desire, which was naturally strong, had disappeared for about twelve months.

When admitted under my care into University College Hospital, in May, 1864, the following notes were taken of his condition:—

A very-strongly built man, much disfigured by an eruption on his face, and elsewhere. His eyes suffused; voice very husky. Pulse between 80 and 90 in the minute, weak. His face is studded with numerous round, hard elevations, varying in size from pins' heads to large peas, either of the usual skin colour, or paler. They are present on the forehead, cheeks, chin, nose, and ears. Some are soft and fluctuating, and on section a puriform fluid escapes. The majority are hard, and have an opaque, solid, white appearance on section. They do not seem to be in any way specially connected with the sebaceous glands or hair-follicles. The eye-lids are thickened and knobby; there is no hair on the outer half of either eye-brow.* There are also on the face several crusts of a darkish-grey or brown colour, like small rupial scabs; on removal of the crust, a sharply-cut circular ulcer is seen. The sclerotics have a muddy aspect, and the conjunctivæ are injected. There is but little hair on his head, and the denuded scalp has a peculiar olive-brown colour in patches, which are elevated, and in some cases present a little desquamation. The external ears are hypertrophied and knobby, with a little scabbing. On the thorax are twenty or thirty tubercles, similar to those on the face, but less prominent; there are also two or three crusts. The skin of the abdomen is mottled, of a brownish colour. On the thighs are also tubercles and numerous crusts, which, when removed, leave a round, unhealthy-looking ulcer. On the arms there are patches of brown discoloration, and the skin feels generally thickened, and studded with tubercles mostly of the colour of the skin but some of a livid purple tint. The backs of the hands are like the arms, but more livid, and have many crusts. A few of the tubercles are soft, and contain sanious pus. The palms of the hands are very dry, but not peeling or tuberculous. At the nape are clusters of tubercles, almost confluent; on the back are also some tubercles, and much brown discoloration.

The case was at first thought to be a form of syphilide, modified, perhaps, by long residence in a tropical climate. He was accordingly treated with mercurial vapour baths twice a week, and five grains of blue pill every night. In about a week he became salivated; he stated however, that he felt much stronger, and in better spirits, than he had done for months.

The soles of his feet were very dry; the toe-nails much thickened,

* Attention has been specially called to this circumstance as a characteristic symptom of leprosy, amongst others, by Dr. Davidson of Madagascar.

and almost horny. The great toe-nail on one foot was separated at the base, and appeared likely to be detached. Some of the tubercles were absorbed, and most of the scabs were detached, the ulcers beneath healing, and in many cases leaving an irregular warty surface of a darkish-red colour. The discoloration of the scalp was rather increased than diminished. There was no albumen in the urine. He suffered usually from a cough, with copious expectoration, and the lungs were found, on examination of the chest, to be emphysematous.

After reading MM. Danielssen and Boeck's description of leprosy in Norway, and consulting several friends, I came to the conclusion that the case was one of leprosy. I had hitherto failed to make observations on the cutaneous sensibility, but now proceeded to do so. He states that he has, since childhood, had a feeling of numbness in the little finger of his right hand, which has increased lately. On pinching the little finger, he feels a darting pain in the course of the ulnar nerve, up to the elbow. No excessive sensibility between olecranon and inner condyle of humerus. There is also a feeling of numbness on the inner side of his right foot; sensation appears to be decidedly less (as estimated by pinching) than on the corresponding part of the left foot, where it would seem to be exaggerated. Examined with compasses, there is a decided deficiency of sensibility, both in the feet and hands. On the dorsum of the right foot, he cannot distinguish the separate points until they are nearly four inches apart; and on the dorsum of the hand, a distance of two inches and a-half was reached, before he recognized two points. In one or two spots on the thighs, near tubercles, there was decidedly an excess of sensibility to pinching. I could not satisfy myself that there was either more or less sensation in the tubercles or the discoloured patches, than in other parts. Owing to his nationality, less dependence could be placed on his answers to questions, and on his account of his sensations, than under other circumstances. A tubercle on the face, rather whiter and softer than the majority, was punctured, and a pus-like fluid escaped, which, when examined microscopically, was found to consist of pyoid cells, with single or multiple nuclei, and a smaller number of round granular non-nucleated cells, varying from $\frac{1}{1500}$ to $\frac{1}{1000}$th of an inch in size. A tubercle, which was hard and reddish-brown in colour, situated on the back of the hand, when cut across, was found to possess a white and smooth section. Under the microscope, it was seen to be made up of an indistinctly fibrous and granular stroma; on the addition of acetic acid, the

whole structure seemed to consist of round and oval nuclei, with one or two indistinct granules in each.

The man assured me from time to time that he felt better; he certainly had more energy, and was in better spirits. His voice continued husky, his cough was troublesome, and the discoloration of the skin increased. No fresh pimples or tubercles appeared. Several ulcers were seen on his soft palate, with raised thickened edges. These existed soon after his admission into the Hospital, and underwent little change during the four months he was under notice.

He continued in the same condition until the 1st of September, when he was attacked with rigors, followed by severe pyrexia. On the 3rd of September, an erysipelatous rash appeared on the face; this soon extended to the scalp. The legs and arms were subsequently affected, and almost the entire surface.

His cough at the same time was severe, with copious expectoration; he had a sore throat, with a difficulty of swallowing, and loss of voice. On the 5th, he was much weaker; tongue dry and cracked; he was unable to swallow. Sub-mucous rhonchi heard at base of each lung, with slight dulness on percussion. Pulse very small and weak.

6*th*.—Weaker. Takes neither stimulants, nourishment, nor medicine.

9*th*.—Blebs formed on the seat of old scabs. General soreness of the surface of body. Breath extremely fetid; dyspnœa great.

11*th*.—Death occurred at 7 A.M., being preceded through the night by muttering, delirium, and great prostration.

Post-mortem examination.—Near some of the tubercles, small blebs containing a purple fluid were seen on the skin. The throat looked irregularly worm-eaten, and had a dusky tinge.

There were a number of large ulcerated patches on the pharynx and the anterior pillars of the fauces. Ulceration extended also to the epiglottis; on the under surface was also a small irregular ulcer, deep, with sharply-cut edges. In the larynx and trachea, there was capilliform and ramiform injection. Pneumonia of both lungs at the base; the right lung in a state of grey hepatization. The right pleura contained half a pint of fluid, and a small abscess, the size of a walnut, on the visceral surface. Some old and some recent adhesions. In the pericardium about half an ounce of clear fluid. Some slight thickening of mitral valve. Kidneys appeared healthy, but congested.

A portion of skin removed from the arm was examined microscopi-

cally. The cuticle not notably changed. The cutis was thickened in many parts, and raised into tubercular lumps, some of which were undergoing a process of softening. On section, the skin was harder and more opaque than normal. Infiltrating the fibrous stroma were seen, under the microscope, innumerable granules, and round and oval nuclei.

Owing to my absence from town, the nerves and spinal cord were not examined, and the examination of the skin was less complete than could have been desired. The observations of Dr. Carter, of Bombay, were consequently neither corroborated nor refuted.

Dr. Thos. Hillier, *7th of March*, 1865.

---

9. *A case of cheloid of Alibert.*

This case was adduced as affording a characteristic example of the disease described by Alibert, under the name of true cheloid (from χηλη, a crab's claw), in distinction from the disease which supervenes in scars. The latter form he called spurious cheloid.

Dr. Addison has used the term true keloid in a different sense, adopting the derivation from κηλις, a scar.

The cheloid of Alibert, exemplified by this case, is characterized by hard shining tubercles, firmly set in the true skin, of a dusky red colour. The patient exhibited was a horse-keeper, æt. 28, enjoying good general health, but rather nervous. He complains of numbness of the left arm, and occasional palpitation of the heart. About eleven years ago, he first observed on the front of his chest a reddish spot like a "blind boil." This came on soon after he had worked about ten days with a threshing fan, the pressure of which was exerted on the chest and on his knee. There was no abrasion or bruising of the skin. This spot gradually extended in length and breadth until it was three inches long by one and a-half wide, and more raised in the centre. It was always hard. Since then two similar tubercular masses have appeared, one above, and the other below, that first formed. This one has now been partly absorbed, leaving a scar-like depression, with some puckering of skin near. The two more recent formations are pinkish, glazed, with ramifying dilated vessels on the surface. They are all elliptical in shape, with the long diameter across the front of the sternum. He states that the

growths are not tender to the touch, but are the seat of sharp pricking pain, like the stab of a knife, especially before rainy weather. He thinks he can generally foretell rain from these sensations.

The disease is clearly one involving the whole thickness of the derma, consisting, it is said, of fibro-cellular exudation, which becomes very dense and very slowly atrophied, with destruction of the true cutaneous tissue. Dr. Thomas Hillier, 21*st of March*, 1865.

---

10. *Horny growth on the face.*

Mr. Holmes (Hon. Sec.) exhibited for Mr. Charles Roberts, of York, a specimen of horny growth removed from the face.

Mr. Roberts' report was the following:—

The horny growth which I enclose was removed by me from the face of an old woman, about 75 years of age, the wife of a blacksmith residing in a small agricultural village, a few miles from York. It was growing from the skin immediately over the edge of the lower jaw, on the left side, at a point corresponding to the angle of the mouth. The patient states, that about three years ago, a small wart (which she had had all her life) became irritable, and, from frequent scratching, bled freely. As the irritation subsided, a horn grew and slowly increased in size for two years, when she broke it "short off."

Woodcut 22.

The enclosed horn has been the produce of the last twelve months, and has increased in diameter and length much more rapidly during the

last three months. (Fig. 22.) The soft bulbous base was very vascular and painful, and the horn, by hanging down into the neck and catching the dress, was a source of great pain and inconvenience to the patient. In removing it, it was only necessary to divide the skin, as the tumour had no connection with the deeper tissues.

Mr. Holmes *for* Mr. Roberts, 21*st of March*, 1865.

---

11. *Drawing illustrating a remarkable condition of the nail and end of one finger, in connection with neuralgia of the same finger and of the upper arm.**

The illustration shows the nail of the middle finger to be much hypertrophied, roughened, and corrugated on its surface, and very jagged at its edges, also great thickening of the cuticle around the insertion of the nail, the whole finger-end being clubbed and enlarged.

The case was that of Elizabeth C., aged about 40 years when she first came under my treatment as an out-patient at St. George's Hospital. She was six months pregnant, and had had a blow at the anterior part of the middle of the left arm, from which she continued to have great pain, and for which she had a blister applied.

A swelling formed at the part of the arm struck, and eventually a small abscess, which was opened, when a tolerable amount of pus escaped. This was in July, 1864. When she came to me as out-patient, she was crying from excessive pain at the affected part, striking to the elbow and behind the arm, and this had existed more or less since the abscess was opened. As there was no swelling, or heat of surface, or other appearances of inflammatory action going on, she was treated with valerian and assafœtida, and subsequently the whole arm was strapped with belladonna plaister, and ten grains of Dover's powder given every night. Afterwards the opium liniment was applied, and quinine and iron given along with valerian. All this treatment produced no amelioration of the pain, and I determined to try the subcutaneous injection of morphia in the vicinity of the painful part. Accordingly Mr. Pick, one of our house-surgeons, injected half a grain. This was unattended by any relief, and it was accordingly repeated at the end of one week, and this time with the most decided benefit, after the expiration of two days, during which she had considerable uneasiness all up the arm. The pain was so relieved that she said she

* For the original drawing, I am indebted to Mr. J. Cavafy.—J. W. O.

had not felt "*so easy for months*," At the end of a week, she expressed herself as being "all right," and "first-rate." After this she had an attack of bronchitis, for which she remained three or four weeks a patient. When dismissed, there was no pain whatever at the former seat of pain, but in the axilla and at the back of the elbow a certain degree of aching pain was felt, though quite insufficient to cause her any longer to come. There was, however, at a point about half an inch to the inner side of the scar resulting from the opening of the abscess, a small rounded and movable "lump" immediately beneath the skin, which was free from any pain, unless when touched, and then it was very tender. This had never been noticed before. It gave one the impression of being a small neuromatous tumour.

She re-appeared at the Hospital after several months, having had a child born, complaining of much pain at the old part, and also of much pain and numbness down the middle finger of the hand. She has continued off and on ever since, finding relief to her pain from nothing so satisfactorily to herself as from subcutaneous injections of morphia and aconite; but even from these the subjugation of pain only remains for a few hours, and the drug has to be used in such doses as produce considerable headache.

Dr. John W. Ogle, 18*th of April*, 1865.

---

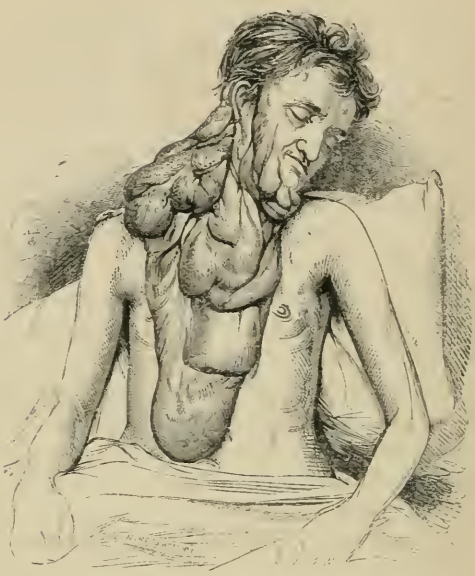
12. *Photographs of pendulous growths from the surface of the body.*

Sarah A. H., æt. 34, a single woman, admitted into the West Riding County Asylum on October 17th, 1864. Is an epileptic, and has attacks of mania after epilepsy, which she has had for some years.

Was formerly employed as a winder in a worsted mill, and has lately been living at Dewsbury, but states that she was born, and resided many years, at Kidderminster, in Worcestershire. Has large (apparently) pendulous growths of skin on right half of neck and chin, and partially over the middle of the sternum, extending about as low as the umbilicus, and also behind, over the cervical and upper (three or four) dorsal vertebræ. The exact attachments of these growths are, as far as can be made out, as follows:—In front (Fig. 23), they extend along the median line, from the chin to the sternum, as low down as a line drawn across from nipple to nipple; and behind, along the median

line, over the whole of the spines of the cervical, and three or four upper

Woodcut 23.



dorsal, vertebræ. (Fig. 24.) They cover the right side of the neck, extending a little above the right ear; they also involve the right half of the chin, and extend across the median line towards the left side, as far as the first molar tooth on that side. There is a smaller growth on the upper part of the right shoulder, which on admission was ulcerated, but has since healed and grown from half to three-quarters of an inch. The folds of skin hang down as low as the umbilicus in front, not quite so low behind. The skin is excoriated between the folds in several places, and is more or less corrugated and partially covered with hair; it resembles in some measure that of the scrotum, more particularly on the chin and right side of the neck.

The patient said she first noticed the growth when about fourteen years of age; that it commenced behind on the nape of the neck, and also just below the chin; and that it has gradually extended and increased in size since that time. As far as her statement can be trusted, the growth commenced like the one on the right shoulder (not shown well

in the photograph) which has increased in size since her admission,

Woodcut 24.

but the attachments of the folds of skin, in front and behind, have not altered for some years.

Her father was subject to moles; the rest of her family are healthy.

This patient had several epileptic fits, followed by excitement (cerebral), lasting for a few days after them. She was found dead in bed, on her face, at 6 A.M., on March 4th, 1865, having apparently died from suffocation during an attack of epilepsy. Unfortunately, no *post-mortem* examination was made. There appeared some enlargement or growth taking place on the scalp above the right ear and rather behind it, previous to her death.

Dr. Murchison *for* Dr. Henry G. Wright, 16*th of May*, 1865.

XI.—MISCELLANEOUS.

1. *Series of blood-crystals.*

A great variety of opinions prevails on the subject of blood-crystals, and a still greater confusion of names is the result, so that our younger pathologists are often puzzled in ascertaining in what particular category to place any given crystal. In order to simplify the subject, Dr. Harley showed to the Society a series of the different kinds of blood-crystals, each possessing such well defined characters as to constitute, he thought, a separate group.

1st. The term *Hæmatoidin* crystals should be retained for those formed under pathological conditions—apoplectic clots, &c. These are short, broad, quadrilateral prisms, with oblique ends, and are generally of a yellowish-red colour. (Plate VII. c, Fig. *a*, 1 and 2.)

2. The name *Hæmin* crystals is applicable to those first described by Teichmann as being produceable by the action of chemical agents upon blood. They are smaller, and much darker than the hæmatoidin variety, being also narrower in proportion to their length. They are very readily prepared by boiling a small fragment of dried blood, in a test tube, along with a few drops of glacial acetic acid, and a little common salt. (Plate VII. c, Fig. *b*.)

3rd. The term *Hæmatin* crystals ought to be reserved for those which spontaneously form in the healthy blood of the splenic vein, or to those obtained from healthy blood, by merely dissolving the walls of the corpuscles, and setting the colouring matter free; as, for example, when blood is shaken up with a few drops of ether or chloroform. These are very much larger than either the hæmin or hæmatoidin crystals, and generally occur in groups, like spicula. Sometimes they are coloured, sometimes almost colourless; the depth of colour in all cases depending, to a certain extent, upon the size and thickness of the crystal. (Plate VII. c, Fig. *c*.)

Dr. George Harley, 18*th of October*, 1864.

---

2. *Specimens of tænia medio-canellata.*

The tænia solium is generally regarded as the commonest species of tænia in this country, and it probably really is so in those districts in which pork enters largely into the diet of the inhabitants. The tænia medio-canellata must, however, be at least as common in London as

the other species, for, during the last few months, I have had under my care no less than five persons infested with this parasite, from whose intestines the six specimens exhibited to the Society have been expelled; whereas, during the same period, I have had but one certain case of tænia solium, although it is true that several hospital patients have neglected to bring the specimens for examination. This great prevalence of tænia medio-canellata in London is possibly due to the large importation of foreign cattle into the London market, the scolex of the tænia medio-canellata being apparently found only in the flesh of horned cattle, several German experimentalists having failed in their attempts to propagate it in the sheep or the pig. The tænia medio-canellata is distinguished from tænia solium by its much greater length, by the greater breadth and thickness of its proglottides or segments, and, above all, by the greater size of the head, which has no hooklets, but is furnished with four large suckers, mostly surrounded by black pigment, rendering them distinctly visible to the naked eye, and also with a central, but less obvious, sucking disk. A beautiful drawing of the head, showing the four principal suckers, may be seen in Dr. Cobbold's recent work on *Parasites*. There are also some distinguishing, but less obvious, peculiarities in the formation of the uterine apparatus. The tænia medio-canellata is of very rapid growth, and the segments are given off in such profusion that they frequently pass spontaneously without any action of the bowels. These mature segments lay their eggs so immediately after their expulsion from the body, that, where they have been expelled with fæces, I have seen the latter, as Küchenmeister describes, appear as if sprinkled with white sand. One of the specimens exhibited is remarkable for the extraordinary length of some of its segments, one of which measures two feet and a-half. The case, from which two of the other specimens exhibited were obtained, well illustrates the peculiar obstinacy with which the head of this species of tænia resists the action of anthelmintics. I was first consulted in May, 1863, for a young gentleman, æt. 4, who was said to be suffering from tape-worm for which various remedies had been tried. As on former occasions, the treatment employed was only temporarily successful. After an interval of about eleven weeks the segments began to re-appear, and he was prescribed for by a physician in Scotland, where he then was, with the same result, for after a similar interval I was again consulted for him in November, 1863, and succeeded in procuring the expulsion, almost entire, of two large specimens of tænia medio-canellata,

wanting, however, the heads. As was therefore to be apprehended, the segments re-appeared in February, and again in May of the present year, on which latter occasion the head of one of the two parasites was expelled. The other grew again, and in August once more began to give off mature segments, when a repetition of the treatment succeeded at length in bringing away the second parasite entire.

Dr. Greenhow, *6th of December*, 1864.

---

3. *Voluntary muscle in fever.*

Specimens of voluntary muscle, taken from cases of typhoid fever, fatal in the third week, were shown under the microscope. They were portions of the rectus abdominalis and adductor magnus muscles, which were selected as being those most liable to suffer in the degeneration discovered by Zenker. The observations of this author were confirmed by the specimens exhibited, some fibres showing waxy degeneration of the sarcous elements, so that the sarcolemma was stuffed with masses of transparent, highly refracting substance; and most fibres showing fatty degeneration, from the earlier stages, in which the cross striæ were obscure, to the more advanced stages, when the sheath of the fibre was filled with granules and globules.

The degenerations in question were connected by Zenker with the occurrence of abscesses in the voluntary muscles, of which instances were on record in cases of typhoid, and which were met with most in the rectus abdominalis. Spontaneous luxation of the hip-joint was stated also in Zenker's treatise to be occasionally witnessed after typhoid, and to be connected also with this degeneration. In the opinion of the exhibitor, these degenerations might be an indication to the eye of a very important set of chemical changes, which the febrile action of typhoid caused in the albuminous tissues throughout the body.

At the time the specimens were shown, the appearances noted in them had not been met with in cases of typhus, though there was reason to think that they did occur in that disease. But since that time, the voluntary muscles have been examined in cases of typhus proving fatal at a late period, in the third week of that fever, and precisely the same degenerations as in typhoid have been observed.

Dr. George Buchanan, *7th of March*, 1865.

---

4. *Abscess in body of rectus muscle from a case of enteric fever.*

Charles M., æt. 37, was admitted into the London Fever Hospital, on September 24th, 1864, and died on October 13th, on the thirtieth day of an attack of enteric fever. The attack was characterized by successive crops of rose spots, persistent diarrhœa, delirium, moist râles over the back of the chest, and for the last two days of life by copious hæmorrhage from the bowels. There was never any pain or marked tenderness in the region of the abdomen.

Post-mortem examination.—There was extensive ulceration of the lower two feet and a-half of the ileum. All the sloughs were detached, and the bases of many of the ulcers were formed by denuded peritoneum. Three of the ulcers had large perforations in their centres, owing to a sloughy portion of the membrane having fallen out during the washing of the bowel. There was no peritonitis. In the belly of the right rectus abdominis muscle was a cavity the size of a chestnut, filled with a thick, reddish-yellow fluid, like pus mixed with blood, and exhibiting under the microscope numerous rounded corpuscles about the size of those of pus, but containing no very characteristic nuclei, together with disintegrating blood corpuscles and a quantity of albuminous and pigmentary granular matter. The posterior wall of the cavity was formed by the fascia of the muscle; anteriorly and laterally the cavity was bounded by the muscular tissue, which was softened, and presented an uneven ragged surface. On microscopic examination, many of the fibres in this softened muscle appeared perfectly normal, but others presented fatty degeneration in all its stages, and in a few the sarcolemma was distended with masses of a transparent, structureless material, strongly refracting light.

Remarks.—The abscess in this case was no doubt the result of hæmorrhage into the substance of the muscle. Hæmorrhage into the substance of the muscles is not uncommon in continued fevers. It is much more common in typhus than in enteric fever, and in both the rectus abdominis muscles are particularly liable to be implicated. The recently published researches of Professor Zenker of Erlangen (*Ueber die Veränderungen der Wilkürlichen Muskeln im Typhus Abdominalis, Leipzig*, 1864) have shown that these hæmorrhages are due to disintegration and rupture of the muscular fibres. He describes two forms of degeneration, one in which the striated structure of the muscle dis-

appears, and the sarcous matter is converted into a quantity of minute granules, and the other, in which the sarcolemma becomes filled with masses of a transparent, strongly refracting, waxy substance. Zenker's observations were made in cases of enteric fever, but apply equally to exanthematic typhus. The softened condition of the muscular tissue of the heart in typhus has long been familiar to English pathologists, and its dependence on granular degeneration of the muscular fibres was pointed out in 1862, in my work *On the Continued Fevers of Great Britain* (pp. 237, 557). Dr. Murchison, 7*th of March*, 1865.

---

5. *Dry gangrene of the right hand, occurring suddenly in a middle aged woman.*

The patient, a married woman, æt. 45, was the subject of some cardiac disease.

Gangrene appeared suddenly in the fingers of the right hand, and extended above the wrist. It was remarked at the time that the temperature of the axilla became very low, though the limb further down seemed to have its natural warmth. Six months elapsed from the first appearance of the gangrene till the entire separation of the dead from the living parts. At the end of that time a good stump was made by simply sawing across the denuded radius and ulna. The woman lived many years afterwards.

This case was probably gangrene from embolism.

Mr. Partridge, 21*st of March*, 1865.

---

6. *Trichiniasis.*

Charles G., æt. 68, a native of Jersey, was admitted as a "casual" patient into the Whitechapel Workhouse on December 24th, 1864. He complained of pains in his chest, with cough and expectoration; he walked with a peculiar shuffling gait, but nothing remarkable was noticed in his symptoms. His appetite was always good. Very little of his history is known previously to December 24th, except that he had been several times in France. He was seized with a difficulty of breathing on March 7th, 1865, and died on the following day, having been confined to his bed only thirty hours.

On making a *post-mortem* examination of his body, in the dissecting-room of the Middlesex Hospital, there was found extensive pleurisy and

pneumonia of the right side, sufficient to cause death. On examining the muscles, it was found that they contained a large number of trichinæ spirales, all enveloped in cysts, which had become more or less calcareous, and thus very conspicuous to the naked eye. The muscles were well developed and showed no signs of wasting. The muscles containing the largest number of trichinæ were those of the neck, chest, and upper arm, particularly the pectoralis major, deltoid, and biceps. Those of the abdomen and thigh contained a much smaller number; while in the sole of the foot they were comparatively rare. The muscles of the abdomen, however, contained a large quantity of fat between the bundles of muscular fibre, which accounted for the small number of trichinæ found in this region. They abounded in the larynx and pharynx, also in the upper part of the œsophagus, but they could not be found in the lower half, or in any of the purely involuntary muscles, such as those of the stomach. None were found in the heart or in any of the muscles within the orbit, although they were plentiful in the orbicularis palpebrarum. In spite of a copious injection of Burnett's fluid into the arteries of the subject, the trichinæ showed unequivocal signs of life when removed from their cysts.

It was noticed that the muscular fibres near the surface of the muscles, especially towards their tendinous extremity, contained a larger number of trichinæ than the more central parts of the same muscles.

Dr. Cobbold fed various animals with the diseased flesh; several were afterwards killed and examined; these, however, gave only a negative result, probably from having vomited the lumps of muscle given to them. A hedgehog which had been fed with the muscle, died about three weeks afterwards from trichiniasis. The muscles of the animal were found to contain a very large number of trichinæ, nearly fully developed, but not yet enveloped in cysts.

Dr. Robert Liveing, 21*st of March*, 1865.

---

7. *Fatty tumour from the recto-vaginal septum. New mode of preserving morbid preparations.*

This tumour was removed from the recto-ischiatic fossa. It had completely closed the vagina in a young lady. It was lobulated, and weighed two pounds when removed. There was no difficulty in the operation, and the patient recovered well. The specimen was shown to make

known a very cheap and efficient mode of preserving morbid preparations. It was simply placed on a sheet of glass, a little ammonia placed beside it on blotting-paper, and then a glass shade was put on and sealed round the edges with a little lard. This specimen had been so preserved nearly two years, and it retained its original appearance almost as well as a wax model. Mr. Wells said that chloroform was said to be as good a preservative as ammonia, and if so it might answer better, as it would not saponify fat.

Mr. Spencer Wells, *4th of April*, 1865.

---

8. *Case of fatal abscess in the rectus femoris muscle, giving rise to symptoms which were supposed to have been those of sciatica, and treated accordingly.*

The patient, George A., æt. 46, was admitted into St. George's Hospital, August 31st, 1863, with acute pain extending from the hip to the knee, along the outer and back part of the thigh. This pain had existed for six days, and before that period for a day or two the leg had been very stiff. He had been treated as suffering from sciatica, and when he came into the Hospital he was further treated on the same supposition. No symptom or condition was set up to excite suspicion that the case was of a more urgent character until the evening of the 4th of September, when, somewhat suddenly, he began to be delirious. He passed a very restless night, and perspired profusely. On the day afterwards he was quite confused in mind, and unable to give any account of himself; the skin was hot, the pulse weak, but the tongue was clean, and there was no agitation or tremor of muscles. Ammonia and chloric ether were given, and morphia at bed-time. His symptoms did not abate, and prostration increased; albumen was found in the urine. He sank and died on this day (the 5th).

Post-mortem examination.—Thorax. The heart was soft and flabby, and the lungs contained a patch of so-termed secondary deposits. Evidence of slight recent pleurisy existed. *Abdomen.* The liver was fatty, but otherwise the organs were natural. *Cranium.* The brain was somewhat more vascular than usual, and more than an ordinary amount of fluid existed in the ventricles. *Leg.* An elevation was noticed about the outer part of the thigh, and on inspection of the limb a cavity was found in the substance of the rectus femoris muscle, capable of holding

a Tangerine orange, having shreddy discoloured walls, and full of a brownish-red viscid puriform fluid. The veins in the neighbourhood were found to be quite natural.* Dr. Ogle, 16*th of May*, 1865.

9. *Muscles and tendons forcibly pulled from the wrist by machinery.*

A man, æt. 35, presented himself at the Westminster Hospital, carrying two of his fingers, the index and middle ones of his right hand. They had been caught in the machinery of a steam-engine, which completely severed them, and at the same time drew them into the machine, and forcibly pulled out the entire tendon of the flexor profundus digitorum muscle attached to one finger. The wound did not extend beyond the metacarpo-phalangeal joint, and subsequently healed kindly. Such cases have before occurred, but their rarity necessarily invests them with some amount of interest. Dr. Gibb, 16*th of May*, 1865.

XII.—SPECIMENS FROM THE LOWER ANIMALS.

1. *Tuberculous lungs of an antelope (Rietboc; Eleotragus arundinaceus).*

The dried lungs and a wax cast of the recent appearances were exhibited for the purpose of showing that nearly every part of the pulmonary structure was occupied by tubercular deposit, so that it was not improbable that in this, and in other like cases, the lining membrane of the trachea partly performed the office of aerating the blood. The lungs of many antelopes in confinement were tuberculous, but the spleen had never been found affected with this disease, although among the *Quadrumana* and other orders this organ was often in a tuberculous condition, the liver in many instances being sound.

Dr. Crisp, 18*th of October*, 1865.

* Dr. Ogle related this case in connection with one of disease of the lower part of the spinal column, which had been treated as one of sciatica (see p. 34), and adduced both in consequence of the interest which had lately been excited by the death of the Czarewitch, by reason of disease of the spine, which was thought to be rheumatic lumbago.

2. *Disease of lower jaw-bone of an antelope.*

Dr. Fenwick showed the lower jaw of an antelope. It was so soft as to be easily cut with a knife, and in parts presented cavities filled with a bloody fluid. He stated that this was a very common affection in animals of this class when in confinement, and might, he thought, be attributed to the want of their natural food.

Dr. Fenwick, 15*th of November*, 1864.

---

3. *Tubercle of the spleen of a young ourang* (*Simia satyrus*) *with wax-casts.*

The right lung was in a state of grey hepatization, and the spleen, which had a supplementary one attached to it, had several small tubercles on its surface. The spleen was the only organ affected with tubercle; and the exhibitor said that he had met with the same localization of tubercle in other quadrumana; but he believed that in man tubercle was never confined to the spleen alone. The *os penis* of this animal was also exhibited, a discovery which was thought tended much to lower these brutes in the animal scale.

Dr. Crisp, 17*th of January*, 1865.

---

4. *Morbid specimens, casts in wax and drawings, to illustrate the various forms of tubercle in the lower animals.*

The exhibitor said that he had never found tubercle in an invertebrate animal, but in fishes he had seen tumours that had some resemblance to tuberculous deposit in the higher vertebrata. One peculiarity in the lung tubercle of mammals and birds was the general absence of cavities, and the large amount of earthy matter in many orders, especially in the ruminants. Another important fact he had before mentioned, was the comparative infrequency of tubercle in the purely animal feeders. The lungs, spleen, and kidneys of a Grivet monkey (*Cercopithecus engythithia*) were shown, all of them studded with tubercles; those on the peritoneum were very vascular, about the size of a millet seed, and connected with the small branch of an artery. A portion of the lung of a Bactrian camel (*C. Bactrianus*), which had recently been dissected, was also exhibited. It consisted chiefly of nodules, varying in size from a pea to that of a nut, and both lungs were throughout affected

with tubercles, which contained a large amount of earthy matter. The bronchial glands were much enlarged, and they contained so much earthy material that on drying they were seen to be hard and stone-like. It was well known that the blood corpuscles of the *Camelidæ* were of an elliptical form, unlike that of all other mammals; but the blood of this animal, although the spleen and liver were sound, contained a very large number of white corpuscles which were *round*, and about three times the short diameter of the red discs. Some glands in the cæcum, colon, and ileum of this animal, not before described, were also exhibited. In both the above-named animals the liver was sound, and this explained the prolongation of life under such an amount of lesion of pulmonary structure, the liver evidently taking on a part of the office of the lungs. When both liver and lungs were extensively diseased, life was soon extinguished. The camel and the monkey had been in a travelling menagerie, where limited space, unnatural food, and a vitiated atmosphere would all tend to occasion the lesions enumerated. Tubercle in wild animals (excepting rabbits in unhealthy localities) was rarely or never met with.

Dr. Crisp, *4th of April*, 1865.

---

5. *Diseased crania of the Quadrumana.*

The skulls were those of a dog-faced baboon (*Simia cynocephalus*), and of a pig-faced baboon (*Cynocephalus porcarius*); both animals had been in confinement in this country, and in both the cranial and facial bones were much thickened, the structure of the bone being of a uniform spongy character. In a third specimen exhibited, the bones of the cranium were light and spongy, and the outer table in many parts deficient. Dr. Crisp said it was interesting to compare the diseases of the apes and monkeys with those affecting the human family, and he found a great amount of difference; he believed that there was no example to be found of a like hypertrophy of the bones of a child, but in the Hunterian Museum were two adult human skulls, in which the bones of the cranium were much thickened (pp. 2858, 2859), but it was believed that these skulls were taken from grave-yards, and no correct history was attached to them. In examining the skulls of a great many of the coloured races in the Hunterian Museum and in other places, he (Dr. Crisp) was struck with the general absence of decay in the teeth, and the same

remark applied to the teeth of the quadrumana, which were very rarely found diseased. The observance of a more simple diet, and that generally composed of vegetable matter, would probably account for this.

Dr. Crisp, 16*th of May*, 1865.

---

6. *Diseased renal bodies in a camel.*

These were taken from a camel, the morbid appearances of the lungs of which animal were described on a former occasion (see p. 280). The animal was killed in consequence of great debility and emaciation. One renal body weighed about an ounce, and the other was of the natural size. The former body was chiefly composed of hard nodules, similar to those in the lungs, and no part of it was in a normal state. The other renal gland was infiltrated with tuberculous deposit in an incipient form. Little could be learnt of the symptoms, but the lung disease, before described, was alone sufficient to account for death.

Dr. Crisp said that he wished to correct an important error respecting the effect of extirpation of the renal bodies of the lower animals. In 1858, a rat (now in spirits at the College of Surgeons) was exhibited, that had had both renal bodies removed. It was stated by Dr. Harley, that the animal (not three years old) *was blind, and losing flesh from old age, so that it was killed.* Dr. Crisp said, in opposition to this conclusion, that the rat usually lived to the age of ten or twelve years, and he believed that no animal would attain its natural term of existence after the extirpation of the renal bodies.

Dr. Crisp, 16*th of May*, 1865.

INDEX.

Abdomen, great distension of, from hydatids in liver - - 157
Abscess of the cerebellum, and disease of temporal bone - - 20
„ in rectus muscle from a case of enteric fever - - - 275
„ in rectus femoris muscle, fatal: supposed sciatica - - 278
„ psoas, depending upon tubercular abscess in the kidney - 175
Addison's disease, case of - - 243
„ — case of - - - 247
„ — see *Supra-renal Capsules.*
Amputation of penis, slitting up of urethra to prevent contraction of orifice - - - 192
Amyloid disease of liver - - 147
Andrew (Dr.), thrombosis of cerebral sinuses, with apoplexy of optic thalami, from anæmia - 27
„ cerebro-spinal meningitis - 28
„ primary cancer of left lung, and of mediastinal glands - - 51
„ congenital malformation of pulmonary valves - - 81
„ aneurism of mitral valve - 91
„ obliteration of the inferior vena cava - - - - 92
„ malignant disease of uterus; secondary deposits in lungs - 198
Aneurism of the aorta - - 98
„ of aorta, pressing on pulmonary artery - - - 76
„ of aorta, with rupture into the right ventricle of the heart - 96
„ of basilar artery, rupture into sheath of spinal cord - - 83
„ of the heart, ruptured - 122
„ of mitral valve - - 91
„ thoracic, involving the arteria innominata and arch of the aorta 123
„ dissecting, of the abdominal aorta 63
Animals, specimens from the lower 279-282
Antelope, disease of lower jaw-bone of 280
„ tuberculous lungs of an - 279
Antimony, butter or chloride of, poisoning by - - - 125
Anus, artificial, in left loin, for cancerous stricture of rectum - 146
Aorta, in one trunk, with pulmonary artery from the heart - 62
„ extensive disease of, in a young man, sudden death - - 85
„ aneurism of the - - 98
„ — of, pressing on pulmonary artery 76
„ — of, with rupture into the right ventricle of the heart - 96
„ — thoracic, involving arch of the 123
„ — dissecting, of abdominal - 63
„ rupture of, from injury - 79
„ disease of trachea opening into 52
Aortic valves, rupture of one of - 77
Aphonia, congenital, with excrescences in larynx - - - 37
Apoplexy of optic thalami, and thrombosis of cerebral sinuses - 27
„ pulmonary, in case of diphtheria 46
Arachnoid, cyst in the cavity of - 6
Artery, basilar, aneurism of - 83
„ left internal carotid, rupture of 85
„ right middle cerebral, obstruction by clot, in patient with secondary syphilis - - - 1
„ iliac and femoral, embolism of, in case of typhus - - 93
„ innominata, thoracic aneurism involving - - - 123
„ pulmonary, in one trunk, with aorta from the heart - - 62
„ — coagulum in, occurring after a natural labour - - 87

Artery, pulmonary, *continued.*
,, — plugging of branches of, in rheumatic fever, rapid death - 71
,, — pressing of aneurism of aorta on 76
,, splenic, perforation of, by large chronic ulcer of stomach - 137
Asthma, grinder's, diseased lung from a case of - - - 59
Atrophy of the brain, from an idiot 20
,, of left cerebral hemisphere, with atrophy of the opposite arm - 5
,, of kidney, and supra-renal capsule 166
,, of the liver, supervening on jaundice 152
Bagshawe (Dr.), case of ruptured aneurism of the heart - - 122
,, suppression of urine for ten days; left kidney destroyed; ureter impervious, &c. - - - 176
Ballard (Dr. Thomas), tuberculous disease of the kidney - 180
Barlow (Dr. G. Hilaro), case of cirrhosis of the lung - - 39
,, *report* on ditto, by Dr. H. G. Sutton 42
Bennett (Dr. Risdon), ulcer of transverse colon, communicating with the stomach - - - 142
Bickersteth (Mr. E. R.) case of mesocolic hernia - - - 139
,, case of fibroid growth in the tibia 227
,, *report* on ditto, by Mr. J. W. Hulke 229
Bile duct, hydatid tumour of liver bursting into - - - 160
Bladder, calculus adhering to the mucous lining of - - 172
,, of a girl, hair-pin removed from, by the high operation - - 174
,, malformation of - - 169
Blood, effusion of, from ruptured aneurism, into the sheath of the spinal cord - - - - 83
Blood-crystals, series of - - 272
Bone, congenital deficiencies of, in cranium - - - 224
Bones, diseases, &c., of - 212-230
Bony deposit in mitral valve, with congenital malformation - 89
Bowel, see *Intestine.*
Brain, atrophy of, from an idiot - 20
,, atrophy of left cerebral hemisphere, and of right arm - - 5
,, carcinomatous growth of, with ulceration of inner surface of cranium 4
Brain, *continued.*
,, gliomatous tumour of - - 23
,, softening of, in case of general paralysis - - - 26
,, tubercular disease of, with loss of use of language - - 14
Breast, see *Tumour* (mammary).
Bristowe (Dr.), obstruction by clot of right middle cerebral artery in patient with secondary syphilis 1
Broadbent (Dr.), dilated kidneys in a child; congenital hydro-nephrosis 164
,, *report* on ditto, by Dr. G. Harley and Dr. Broadbent - - 164
,, atrophy of kidney and supra-renal capsule - - - 166
Bronchial casts, case of - - 48
Brooke (Mr.), fleshy tumour of the thigh - - - 237
Buchanan (Dr. George), voluntary muscle in fever - - 274
Bursting, *post-mortem*, of the stomach 130
Cæcum, colloid cyst in the wall of 138
Calculi, numerous spherical, passed by urethra - - - 181
Calculus adhering to the mucous lining of the bladder - - 172
,, removed by lithotomy, having a blood-clot nucleus - - 179
Callender (Mr.), *report* on Dr. Ogle's case of cancer of supra-renal capsules - - - 251
Camel, diseased supra-renal capsules in a - - - 282
Cancer, primary, of larynx, destroying the epiglottis - - - 54
,, primary, of left lung and of mediastinal glands - - 51
,, of ovaries, producing obstruction of bowels - - - 196
,, of the prostate - - - 190
,, of supra-renal capsules of a child 250
,, of right supra-renal capsule - 250
,, of thyroid gland, causing pressure of trachea - - - 253
,, of uterus; secondary deposits in both lungs - - - 198
,, cancerous deposit in the heart 99
,, — references to published cases 198
,, cancerous nodules of peritoneum 196
,, colloid, of peritoneum - - 128
,, — in wall of the cæcum - 138
,, epithelial, primary, of epiglottis and pharynx - - - 53

Caries of lumbar vertebræ, in case of paraplegia - - - 34
Cataract, black, two cases- - 230
Cayley (Dr. William), tumour pressing on the spinal cord - - 21
,, gliomatous tumour of the brain 23
,, rupture of the left internal carotid artery - - - 85
,, amyloid disease of liver - 147
,, tumour of supra-renal capsule 246
,, cancer of right supra-renal capsule 250
Cerebellum, abscess of, and disease of temporal bone - - 20
Cheloid, see *Keloid.*
Chordæ tendineæ, ruptured, of mitral valve - - - 82
Circulation, organs of, diseases, etc., of - - - 62-124
Cirrhosis of the lung - - 39
Clarke (Mr. Lockhart), on paraplegia after fever - - - 33
Coal-miner's black lung - - 60
Coagulum in pulmonary artery, occurring after a natural labour - 87
Colloid cancer of peritoneum - 128
,, cyst in the wall of the cæcum - 138
Colon, transverse, ulcer of, communicating with the stomach - 142
Convulsion, epileptiform, in case of right hemiplegia - - 16
,, — in case of hæmorrhage into right hemisphere of brain - 17
Crania, diseased, of the quadrumana 281
Cranium, sections of, showing the incorrectness of applying to the inner table the expression, "Lamina vitrea" - - - 217
,, explanation of the form of holes in, made by gun-shot - - 217
,, congenital deficiencies of bone of 224
,, encephalocele of the anterior part, three examples - - 8
,, — of the posterior part - 12
,, — ditto - - 35
,, fracture of, with discharge from the meatus auditorius externus - 213
,, depressed fractures of - - 213
,, ulceration of inner surface of, with carcinomatous growth of brain 4
Cricoid cartilage, necrosis of, with incipient ossification - - 37
,, — necrosis of, recovery - 45
Crisp (Dr.), poisoning by butter (chloride) of antimony - - 125
,, stomach, duodenum, and jejunum of a fat man weighing about eighteen stones - - 130
Crisp (Dr.), *continued.*
,, tuberculous lungs of an antelope (Rietboc) - - - 279
,, tubercle of the spleen of a young ourang - - - 280
,, morbid specimens (casts in wax), of various forms of tubercle in the lower animals - - 280
,, diseased crania of the quadrumana 281
,, diseased renal bodies in a camel 282
Crystals, blood-, series of - - 272
Curling (Mr. T. B.), cancerous stricture of the rectum — an anus established in left loin for relief of symptoms - - 146
Cyanosis, open foramen ovale without 91
Cyst in the cavity of the arachnoid 6
,, with semi-transparent parietes, of supra-renal capsule - - 252
,, colloid, in the wall of the cæcum 138
,, ovarian, see *Ovarian cysts.*
Dantzig, cases of cerebro-spinal meningitis, in epidemic of - 30
Deposits, fibrinous, in kidneys, from embolism of renal arteries - 166
Diarrhœa, typhus complicated with, intestines from a case of - 124
Dickinson (Dr.), *post-mortem* bursting of the stomach - - 130
,, two cases of enteritis - - 132
,, colloid cyst in the wall of the cæcum - - - 138
,, intermittent hæmaturia - 174
,, psoas abscess depending upon tubercular abscess in the kidney 175
,, urine containing a large quantity of colouring matter resembling indigo 181
,, malignant disease of prostate 190
,, rupture of uterus in an early period of pregnancy - - 203
,, case of Addison's disease - 243
,, *report* on Dr. Ogle's case of cancer of suprarenal capsules - 251
,, see *Mac Laurin (Dr.).*
Digestion, Organs of, diseases, etc., of - - - 124-164
,, 1. Stomach, intestines, etc. 124-147
,, 2. Liver and its appendages 147-164
Diphtheria, with pulmonary apoplexy, etc. - - - 46
,, malformation of septum ventriculorum in a case of death from 80

Diphtheritic membrane from trachea 61
Diseases, etc., of the nervous system 1-37
,, of the organs of respiration 37-62
,, of the organs of circulation (vascular system) - - 62-124
,, of the organs of digestion 124-164
,, — 1. Stomach, intestines, etc. 124-147
,, — 2. Liver and its appendages 147-164
,, of the genito-urinary organs 164-212
,, — 1. Kidneys, bladder, calculi, etc. - - 164-183
,, — 2. Genital organs, male 183-195
,, — 3. ditto, female - 195-212
,, of the osseous system 212-230
,, of the organs of special sense 230-236
,, tumours, cysts, etc. - 236-242
,, ductless glands: A, the spleen 242-243
,, — B, suprarenal capsules 243-252
,, — C, thyroid gland - 253
,, of the skin - - 254-271
,, miscellaneous specimens 272-279
,, specimens from the lower animals 279-282
Diverticulum ilei, strangulation of intestine by - - - 126
Duodenum, jejunum, etc., of a very fat man - - - 130
Elbow-joint, three years after successful excision - - - 217
Embolism of the iliac, femoral, and other arteries, in a case of typhus 93
,, of renal arteries, fibrinous deposits in kidneys from - - 166
,, of the spleen and lungs in enteric fever - - - 242
Encephalocele of the anterior part of the skull, three examples - 8
,, of the posterior part of the skull 12
,, of the posterior part of the skull 35
Enteric fever, abscess in rectus muscle, from a case of - - 275
,, embolism of spleen and lungs in 242
,, intestines from a case of relapse of 144
,, — of a child who died of - 125
Enteritis, two cases of - - 132
Epiglottis, primary epithelial cancer of 53
,, destroyed in primary cancer of larynx - - - 54
Epilepsy, see *Convulsions* (epileptiform)
Epispadias - - - 193
Excision of elbow-joint, successful 217
,, of head of right humerus, etc., fifty years before death - - 216
Face, horny growth on - 267
Fagge (Dr. Hilton), case of bronchial casts - - - 48
Fatty tumours, see *Tumours*.
Favus, case of, cured without epilation 256
Fenwick (Dr.), disease of lower jaw-bone of an antelope - 280
Fergusson (Mr. W.), milky fluid from tunica vaginalis. Galactocele 184
,, *report* on ditto, by Dr. George Harley and Mr. F. Mason - 184
,, excision of the head of right humerus and glenoid cavity of the scapula, fifty years before death 216
Fever, paraplegia after - - 33
,, voluntary muscle in - - 274
,, enteric, abscess in rectus muscle from a case of - - 275
,, — embolism of spleen and lungs in 242
,, — intestines from a case of relapse of - - - - 144
,, — intestines of a child who died of 125
,, rheumatic, plugging of branches of pulmonary artery in; rapid death 71
,, see *Typhoid, Typhus*.
Fibrin, effused, external to spinal dura mater - - - 34
Fibroid growth in the tibia - 227
Fibrous tumours, see *Tumours*
Finger, remarkable condition of end of one, with neuralgia of the finger and arm - - - 268
Fœtation, tubular - - 197
Foramen ovale, open, without cyanosis 91
Fuller (Dr.), aneurism of basilar artery, — rupture and effusion of blood into sheath of spinal cord 83
Gabriel (Mr. John S.), extensive disease of aorta in a young man; sudden death - - 85
Galactocele: milky fluid from tunica vaginalis - - - 184
Gall-stone, large, passed per anum 159
Gall-stones, case of - - 160
,, series of - - - 148
Gangrene of lower extremities, in case of embolism of arteries, &c. - 93

Gangrene, *continued.*
„ of entire penis, occurring with typhus fever - - 192
„ dry, of right hand - - 276
Gay (Mr.), traumatic abdominal hernia, with rupture of the recti abdominis, involving left epigastric artery 128
„ malformation of penis - 189
„ fracture of skull, with discharge from the meatus auditorius externus - - - - 213
„ lobulated mammary tumour - 240
Generation, Organs of, diseases, etc., of - - - 164-212
Gibb (Dr.), necrosis of the cricoid cartilage; recovery - - 45
„ portion of ossified tracheal rings expelled some months after tracheotomy - - - 46
„ primary cancer of the larynx, destroying the epiglottis - 54
„ necrosis of turbinated bones, etc., treated by aid of the rhinoscope 212
„ muscles and tendons forcibly pulled from the wrist by machinery 279
„ see *Logan* (*Dr.*).
Glands, Ductless, diseases of 243-253
Glands, mediastinal, primary cancer of 51
Glenoid cavity of scapula, excision of, fifty years before death - 216
Gliomatous tumour of the brain - 23
Gooch (the late Dr.), case of inverted uterus removed by ligature during life [related by] - - 208
Greenhow (Dr.), case of diphtheria, with pulmonary apoplexy, and congestion of stomach and ileum 46
„ diseased lung from a case of grinder's asthma , - 59
„ specimen of coal-miner's black lung - - - - 60
„ dissecting aneurism of the abdominal aorta - - - 63
„ case of Addison's disease of the supra-renal capsules - - 247
„ specimens of tænia medio-canellata 272
Grinder's asthma, diseased lung from a case of - - - 59
Growths, pendulous, from surface of body - - - - 269
Gunshot wounds of cranium, explanation of the nature of - - 217
Hæmaturia, intermittent - - 174
„ do. - - - - 183
„ do. urine of - - - 168
Hæmorrhage into right hemisphere of brain; epileptiform convulsions 17
Hair-pin removed by the high operation from a girl's bladder - 174
Hand, right, dry gangrene of - 276
Hare (Dr.), malformation of septum ventriculorum, from a patient who died of diphtheria - - 80
„ large chronic ulcer of stomach; perforation of splenic artery; short duration of stomach symptoms; &c. - - - - 137
„ large ovarian cyst adherent to uterus, in which were three large fibrous tumours - - 199
Harley (Dr. George), series of gall-stones - - - 148
„ the urine of intermittent hæmaturia - - - - 168
„ series of blood-crystals - 272
„ *report* on Dr. F. Robinson's case of atrophy of the liver - - 154
„ *report* on Dr. Broadbent's case of dilated kidneys in a child - 164
„ *report* on Mr. Fergusson's case of galactocele - - - 184
„ *report* on Mr. H. Smith's case of cancer of thyroid gland - 253
Heart with open foramen ovale, without cyanosis; thickening of the pulmonary valves - - 91
„ cancerous deposit in - - 99
„ — references to published cases 108
„ dilatation of right side of, with dense deposit of tubercle in lungs 69
„ ruptured aneurism of - - 122
„ rupture into the right ventricle of, in case of aneurism of aorta - 96
„ ulcerated cavity in the wall of; death from meningitis - 121
Heath (Mr. Christopher), three examples of encephalocele of the anterior part of the skull - - 8
„ fibrous tumour of the scrotum, involving the left testicle - 183
„ cancer of ovaries, producing fatal obstruction of the bowels; cancerous nodules of peritoneum 196
„ see *Power* (*H.*).
Hemiplegia, ulceration of cranium in a case of - - - - 4
„ right, with complete loss of speech, epileptiform convulsions, &c., 16
Hermaphroditism, transverse - 191
Hernia, irreducible, thickening of intestine by pressure of truss on 135

Hernia, *continued.*
„ traumatic abdominal, with rupture of the recti abdominis - 128
„ case of meso-colic - - 139
Herniotomy for the second time, fatal 135
Hewitt (Dr. Graily), *report* on Dr. Slayter's supposed case of inverted uterus - - - 211
Hicks (Dr J. Wale), heart with open foramen ovale without cyanosis; thickening of the pulmonary valves 91
Hillier (Dr. Thomas), case of true leprosy - - - 262
„ case of cheloid of Alibert - 266
Hinton (Mr.), sebaceous tumours in the tympanum - - - 233
„ *report* on ditto by Mr. Toynbee, Mr. T. Smith, and Mr. Hinton 234
„ small tumour within tympanum, cicatrix of membrana tympani 236
Hogg (Mr. Jabez), hæmorrhage into right hemisphere of brain, from patient who died in epileptiform convulsions - - - 17
Holmes (Mr. T.), herniotomy for the second time, fatal; thickening of the gut by pressure of truss on an irreducible hernia - - 135
„ case of malformation of the bladder 169
„ ovariotomy, fatal by diffuse peritonitis - - - 195
„ ovarian tumour successfully removed - - - 207
„ fibro-fatty tumour of the neck in a child successfully removed - 236
„ see *Roberts.*
Horny growth on the face - 267
Hulke (Mr. J. W.), *report* on Mr. „ Bickersteth's case of fibroid growth in the tibia - - - 229
„ *report* on Mr. Windsor's two cases of black cataract - - 233
Humerus, excision of head of right, fifty years before death - 216
Hutchinson (Mr. Jonathan), disease of brain of a tubercular nature, with loss of the use of language 14
Hydatid tumour of liver opening into the lung - - - 154
„ — of liver bursting into bile duct 160
Hydatids in liver, enormous accumulation of - - - 157
Hydro-nephrosis, congenital - 164
Ileum, congestion of, in case of diphtheria - - - 46
Impetigo figurata of the forehead and nose - - - - 255
Indigo, urine containing colouring matter resembling - - 181
Inflammation of internal periosteum of the tibia - - - 225
Intestine, large, from a case of typhoid fever - - - - 127
Intestines of a child who died of enteric fever - - - - 125
„ from a case of typhus complicated with diarrhœa - - 124
„ extensive invagination of - 141
„ fatal obstruction of, by cancer of the ovaries - - - 196
„ case of sloughing of a piece of 145
„ strangulation of, by diverticulum ilei - - - - 126
„ thickening of, by pressure of truss on an irreducible hernia - 135
Invagination of intestine, extensive 141
Jaundice, atrophy of the liver supervening on - - - 152
Jaw, lower, fibrous tumour from near the angle of - - - 223
„ — disease of, in an antelope - 280
Keloid of Alibert, case of - - 266
„ sequel to a case of true, (in *Transactions*, vol. xii., p. 234) - 260
„ or molluscum - - - 261
Kidney, atrophy of - - 166
„ dilated, in a child; congenital hydro-nephrosis - - 164
„ with fibrinous deposits from embolism of renal arteries - 166
„ medullary tumour of - - 171
„ tuberculous disease of - - 180
„ psoas abscess depending upon tubercular abscess in - - 175
„ wasted, from malformation of ureter 181
„ left, destruction of, and ureter impervious in a case of suppression of urine - - - 176
"Lamina vitrea," incorrectness of the term for the inner table of the skull - - - - 217
Language, loss of use of, in a case of tubercular disease of brain 14
Larynx, primary cancer of, destroying the epiglottis - - - 54
„ excrescences in, in case of congenital aphonia - - - 37
„ — in, removed by forceps with aid of the laryngoscope - - 38

Larynx, *continued.*
„ chronic ulceration of - - 44
Lawrence (Mr. J. Z.), melanotic tumour of the orbit - - - 235
Leach (Mr. Harry), thoracic aneurism, involving the arteria innominata and arch of the aorta - - 123
Leared (Dr.), large gall-stone passed per anum - - - 159
„ case of gall-stones - - 160
„ pink lithate deposit - - 176
Lee (Mr. Henry), osteo-myelitis, or inflammation of the internal periosteum of the tibia - - 225
Leg, medullary tumours of, from an infant - - - - 238
Leprosy, case of true - - 262
Lichen inveteratus - - 258
Lichtenberg (Dr.), aneurism of the aorta, with rupture into right ventricle of the heart - - 96
Lithotomy, calculus removed by; blood-clot nucleus - - 179
Liveing (Dr. R.), trichiniasis - 276
Liver, amyloid disease of - - 147
„ atrophy of, supervening on jaundice 152
„ hydatid tumour of, opening into the lung - - - - 154
„ — bursting into bile-duct - 160
„ enormous accumulation of hydatids in - - - - 157
Logan (Dr.), *per Dr. Gibb*, enormous accumulation of hydatids in the liver; great abdominal distension 157
Lung, primary cancer of left - 51
„ cirrhosis of - - - 39
„ embolism of, in enteric fever - 242
„ hydatid tumour of liver, opening into - - - - 154
„ dense deposit of tubercle in, with dilatation of right side of heart 69
„ tuberculous, of an antelope - 279
„ coal-miner's black - - 60
„ Cornish-miner's - - - 57
„ diseased, from a case of grinder's asthma - - - 59
Mackenzie (Dr. Morell), necrosis of cricoid cartilage, with incipient ossification - - - 37
„ congenital aphonia, excrescences in larynx - - - 37
„ laryngeal excrescences removed by forceps with aid of the laryngoscope - - - - 38
MacLaurin (Dr.), *per Dr. Dickinson*, case of sloughing of a piece of intestine - - - 145
Malformation of the bladder - 169
„ of penis - - - 189
„ congenital, of pulmonary valves 81
„ of septum ventriculorum, in a case of death from diphtheria - 80
Malignant disease of prostate - 190
„ — of uterus - - - 198
„ — see *Cancer*.
Mania, ulceration of cranium in a case of - - - - - 4
Martyn (Dr. William), plugging of branches of pulmonary artery in rheumatic fever; rapid death 71
Mason (Mr. Francis), colloid cancer of peritoneum - - - 128
„ diseased prostate gland - 187
„ *report* on ditto, by Dr. Murchison, Mr. Henry Thompson, and Mr. F. Mason - - - 188
„ *report* on Mr. Fergusson's case of galactocele - - - 184
Meatus auditorius externus, discharge from, in fracture of cranium - 213
Medullary tumours, see *Tumours*.
Melanotic tumours, see *Tumours*.
Meningitis, with atrophy of the liver supervening on jaundice - 152
„ death from, in case of ulcerated cavity in the wall of the heart 121
„ cerebro-spinal - - - 28
„ — cases observed in the epidemic of Dantzig - - - 30
Milky fluid from tunica vaginalis: galactocele - - - 184
Miner's (Cornish) lung - - 57
„ (coal) black lung - - 60
Mitral disease, connected with embolism of renal arteries - - 166
Mitral valve, fleshy column of diseased, ruptured during violent vomiting 67
„ aneurism of - - - 91
„ bony deposit in, with congenital malformation - - 89
„ ruptured chordæ tendineæ of - 82
Molluscum or keloid - - 261
Muscles and tendons forcibly pulled from the wrist by machinery - 279
Muscle, rectus, abscess in, from a case of enteric fever - - 275
„ rectus femoris, fatal abscess in, supposed sciatica - - 278
„ voluntary, in fever - - 274
Musculi papillares of tricuspid valves, rupture of one of - - 73
Murchison (Dr.), atrophy of the brain from an idiot - - 20
„ embolism of the iliac, femoral, and other arteries and thrombosis of

Murchison (Dr.) *continued.*
femoral and popliteal veins from a case of typhus fever, &c. - 93
„ ulcerated cavity in the wall of the heart: death from meningitis 121
„ intestines from a case of typhus complicated with diarrhœa - 124
„ intestines of a child who died of enteric fever - - - 125
„ intestines of a patient who died of a relapse of enteric fever - 144
„ hydatid tumour of the liver threatening to burst; paracentesis; recovery - - - 148
„ case of hydatid tumour of the liver bursting into the bile-duct - 160
„ intermittent hæmaturia - 183
„ embolism of the spleen and lungs in enteric fever - - 242
„ abscess in rectus muscle from enteric fever - - - 275
„ *report* on Dr. F. Robinson's case of atrophy of the liver - - 154
„ *report* on Mr. F. Mason's case of diseased prostate gland - 188
„ *report* on Mr. H. Smith's case of cancer of thyroid gland - 253
„ *see Wright* (*Dr. H. G.*).
Nail, remarkable condition of, with neuralgia of the finger and arm 268
Neck, fibro-fatty tumour of, in a child, successfully removed - 236
Necrosis of cricoid cartilage, with incipient ossification - - 37
„ — recovery - - - 45
„ of turbinated bones, treated by aid of rhinoscope - - 212
Nervous System, diseases, etc., of 1-37
Neuralgia of the finger and arm, remarkable condition of nail, &c., connected with - - 268
Norton (Mr. A. T.), disease of temporal bone, and abscess of the cerebellum - - - 20
„ primary epithelial cancer of epiglottis and pharynx, involving the vocal cords - - - 53
Nucleus, blood-clot, in calculus, removed by lithotomy - - 179
Nunn (Mr.), calculus from bladder removed by lithotomy, having a blood-clot nucleus - - 179
„ numerous spherical calculi passed by the urethra - - 181
Œdema of lower extremities in case of embolism of arteries, &c. - 93
Ogle (Dr. J. W.), ulceration of inner surface of cranium, with carcinomatous growth of the brain - 4
„ atrophy of left cerebral hemisphere, with atrophy of opposite arm 5
„ general paralysis of the insane, softening of spinal cord, &c. - 25
„ softening of spinal cord, from a case of general paralysis of the insane, with epilepsy - 25
„ general paralysis and dementia, softening of brain and spinal cord 26
„ paraplegia, commencing like sciatica, caries of the lumbar vertebræ, &c. 34
„ inverted uterus successfully removed by ligature during life (case related by Dr. Gooch) - - 208
„ protrusion of large mass from vagina supposed to be an inverted uterus, removed by écraseur (case related by Dr. Slayter) - - 210
„ *report* on ditto by Dr. John Ogle, Dr. Marion Sims, and Dr. Graily Hewitt - - - 211
„ large mass of carcinomatous deposit in one of the supra-renal capsules of a child - - 250
„ *report* on ditto, by Mr. Partridge, Dr. Dickinson, and Mr. Callender 252
„ cyst, with semi-transparent parietes, of supra-renal capsule - 252
„ remarkable condition of the nail and end of one finger, with neuralgia of the finger and arm - 268
„ fatal abscess in rectus femoris muscle; supposed sciatica - 278
Optic thalami, apoplexy of - 27
Organs of Special Sense, diseases, &c., of - - 230-236
Osseous System, diseases, etc., of 212-230
Ossification, incipient, in case of necrosis of cricoid cartilage - 37
Osteo-myelitis, or inflammation of the internal periosteum of the tibia 225
Ourang, tubercle of the spleen of a young - - - 280
Ovarian cyst adherent to uterus, in which were three large fibrous tumours - - - 199
„ tumours successfully removed 207
„ semi-solid - - - 206
Ovaries, cancer of, producing fatal obstruction of bowels - 196
Ovariotomy, fatal, by diffuse peritonitis - - - - 195

Paracentesis for hydatid tumour of liver, threatening to burst—recovery - - - - 148
Paralysis, general, of insane, with softening of spinal cord - - 25
„ — of insane, with softening of spinal cord - - - - 25
„ — and dementia, softening of brain and spinal cord - - 26
Paraplegia after fever - - 33
„ commencing like sciatica, caries of lumbar vertebræ - - 34
Partridge (Mr.), transverse hermaphroditism - - - 191
„ stump of penis after amputation, showing good effects of slitting up urethra in preventing contraction of its orifice - - - 192
„ gangrene of the entire penis, occurring with typhus fever - 192
„ epispadias - - - 193
„ dry gangrene of the right hand 276
„ *report* on Dr. Ogle's case of cancer of supra-renal capsules - 251
Peacock (Dr.), Cornish miner's lungs 57
„ fleshy column of diseased mitral valve, ruptured during violent vomiting - - - 67
„ cases of cancerous deposit in the heart - - - 99
„ references to published cases of cancer of the heart - - 108
Pendulous growths from surface of body - - - - 269
Penis, gangrene of, occurring with typhus fever - - - 192
„ malformation of - - 189
„ stump of, after amputation, slitting up of urethra to prevent contraction of orifice - - 192
Periosteum of tibia, inflammation of internal - - - 225
Peritoneum, cancerous nodules of 196
„ colloid cancer of - - 128
Peritonitis, ovariotomy fatal by diffuse 195
Pharynx, primary epithelial cancer of 53
Pink lithate deposit - - 176
Playfair (Dr. W. S.), spina bifida in progress of spontaneous cure - 13
„ case of tubular fœtation - 197
„ case of extensive invagination of intestine - - - 141
Poisoning by butter (chloride) of antimony - - - 125
Pollock (Dr. Julius), aneurism of the aorta, pressing upon the pulmonary artery - - - 76
„ ruptured chordæ tendineæ of the mitral valve - - - 82
„ aneurism of the aorta - - 98
„ hydatid tumour of the liver opening into the lung - - - 154
„ case of wasted kidney from malformation of ureter - - 181
Power (Mr. Henry), *per Mr. Christopher Heath*, encephalocele of the posterior part of the skull - 12
„ — opening in septum ventriculorum; pulmonary artery and aorta from the heart in one trunk 62
Pregnancy, rupture of uterus in early period of - - - 203
„ extra-uterine (tubular) - 197
Prostate gland, diseased - - 187
„ malignant disease of - - 190
Psoriasis diffusa and guttata, case of, over the knees - - 254
Pulmonary valves, entire loss of two of the - - - 74
„ — congenital malformation of 81
„ — thickening of, in case of open foramen ovale - - 91
Pus in the theca vertebralis - 26
Quadrumana, diseased crania of - 281
Rectum, cancerous stricture of,—artificial anus - - - 146
Recto-vaginal septum, fatty tumour from - - - 277
Rectus muscle, abscess in, from a case of enteric fever - - 275
„ abdominis muscle, rupture of, in case of traumatic abdominal hernia - - - - 128
„ femoris muscle, fatal abscess in, supposed sciatica - - 278
Renal bodies, see *Supra-renal capsules*.
Respiration, organs of, diseases, etc., of - - - - 37-62
Rheumatic fever, plugging of branches of pulmonary artery in; rapid death - - - 71
Rhinoscope, necrosis of turbinated bones treated by aid of - 212
Roberts (Mr.), *per Mr. T. Holmes*, horny growth on the face - 267
Robinson (Dr. Frederick), dilatation of right side of heart, with dense deposit of tubercle in lungs - 69
„ bony deposit in the mitral valve, with contraction of orifice, with congenital malformation - 89
„ case of meningitis, with atrophy

Robinson (Dr. Frederick), *continued.*
of the liver supervening on jaundice - - - - 152
,, *report* on ditto, by Dr. G. Harley and Dr. Murchison - - 154
Rupture of aorta from injury - 79
,, of one of the aortic valves - 77
,, of left internal carotid artery - 85
,, of diseased mitral valve during violent vomiting - - 67
,, of uterus in early period of pregnancy - - - 203
Sanderson (Dr. Burdon), cases of cerebro-spinal meningitis, observed in the epidemic of Dantzig 30
Scabies, hand of a woman affected by 259
Scapula, glenoid cavity of, excision fifty years before death - 216
Sciatica, supposed, a case of fatal abscess in rectus femoris muscle 278
Scrotum, fibrous tumour of, involving the left testicle - - 183
Sebaceous tumours in the tympanum 233
Sedgwick (Mr.), sequel to a case of true keloid (*Trans.* vol. xii. p. 234) 260
Semple (Dr.), diphtheritic membrane from the trachea - - 61
,, a rare form of skin disease: keloid or molluscum - - 261
Sense, organs of special, diseases, etc., of - - 230-236
Septum ventriculorum, case of opening in - - - 62
,, — malformation of, from a patient who died of diphtheria - 80
Shillitoe (Mr. Buxton), fibrous tumour from near the angle of the lower jaw - - - 223
Sims (Dr. Marion), *report* on Dr. Slayter's supposed case of inverted uterus - - - 211
Skin, diseases of - 254-271
Skull, see *Cranium.*
Slayter (Dr., *of Halifax, Nova Scotia*), protrusion of large mass from the vagina, supposed to be an inverted uterus - - - 210
Sloughing of a piece of intestine - 145
Smith (Mr. Henry), elbow-joint three years after successful excision 217
,, cancer of thyroid gland, causing pressure on trachea - - 253
,, *report* on ditto, by Dr. Murchison and Dr. George Harley - 253
Smith (Mr. T.), Medullary tumour of the kidney - - - 171
Smith (Mr. T.), *continued.*
,, medullary tumours of the leg from an infant seventeen months old 238
,, skull cap showing congenital deficiencies of bone - - 224
,, *report* on Mr. Hinton's case of sebaceous tumours in the tympanum - - - 234
Softening, see *Brain, Spinal cord.*
Spanton (Mr. W. D.), *per Mr. W. Squire*, chronic ulceration of the larynx - - - 44
,, rupture of one of the musculi papillares of the tricuspid valves 73
Specimens, Miscellaneous, 272-279
Specimens from the Lower Animals 279-282
Speech, complete loss of, in case of right hemiplegia - - 16
Spina bifida in progress of spontaneous cure - - - 13
Spinal cord, tumour pressing on - 21
,, pressure upon, and softening of, 34
,, softening of, in a case of general paralysis of the insane - 25
,, ditto ditto - - 25
,, — in a case of general paralysis 26
,, rupture of aneurism and effusion of blood into sheath of - 83
Spleen, etc. - - 242-243
,, embolism of, in enteric fever - 242
,, tubercle of, in a young ourang 280
Squire (Mr. Balmanno), photograph of psoriasis diffusa and guttata, over the knees - - - 254
,, photograph of impetigo figurata of the forehead and nose - 255
,, case of favus cured without epilation 256
,, photograph of lichen inveteratus 258
,, photograph of hand of a woman affected with scabies - 259
Squire (Mr. William), see *Spanton (W. D.).*
Stomach, congestion of, in case of diphtheria - - - 46
,, large chronic ulcer of, and perforation of the splenic artery - 137
,, *post-mortem* bursting of - 130
,, duodenum, etc., of a very fat man 130
Stone, see *Calculi.*
Strangulation of intestine by diverticulum ilei - - - 126

Stricture, see *Rectum.*
Supra-renal Capsules - 243-252
,, Addison's disease of - - 243
,, ditto - - - 247
,, atrophy of - - 166
,, cancer of - - - 250
,, carcinomatous deposit of, in a child 250
,, cyst of, with semi-transparent parietes - - - 252
,, tumour of - - - 246
,, diseased, in a camel - - 282
Sutton (Dr. H. G.), *report* on Dr. Barlow's case of cirrhosis of the lung - - - 42
Syphilitic disease, congenital, of the testes - - - 189
Syphilis, secondary, obstruction of right middle cerebral artery in patient with - - 1
"Tabula vitrea," incorrectness of the term for the inner table of the skull 217
Tænia medio-canellata, specimens of 272
Teevan (Mr. W. F.), two cases of depressed fractures of the skull, no operation performed - 213
,, sections of skulls showing the incorrectness of applying to the inner table the expression, "Lamina, vel tabula, vitrea"- - - 217
Temporal bone, disease of, and abscess of the cerebellum - - 20
Testes, congenital syphilitic disease of 189
,, left, involved in fibrous tumour of scrotum - - - 183
Thigh, fleshy tumour of - - 237
Thompson (Mr. H.), case of calculus adhering to the mucous lining of the bladder - - 172
,, hair-pin removed by the high operation from a girl's bladder 174
,, *report* on Mr. F. Mason's case of diseased prostate gland - 188
Thrombosis of cerebral sinuses, with apoplexy of optic thalami, etc. 27
,, of femoral and popliteal veins, in case of typhus - - 93
Thyroid gland - - - 253
,, cancer of, causing pressure of trachea - - - 253
Tibia, case of fibroid growth in - 227
,, inflammation of internal periosteum of - - - - 225
Tonge (Dr. Morris), right hemiplegia, with complete loss of speech, epileptiform convulsion, paralysis; death - - - 16
,, coagulum in pulmonary artery, occurring after a natural labour 87
Tonge, (Dr. Morris), *continued.*
Toynbee (Mr. Jos.), *report* on Mr. Hinton's case of sebaceous tumours in the tympanum - - 234
Trachea, cancer of thyroid gland, causing pressure of - - 253
,, diphtheritic membrane from - 61
,, disease of, probably syphilitic, opening into the aorta - 52
Tracheal rings, ossified, portions of, expelled after tracheotomy - 46
Tracheotomy, portions of ossified tracheal rings expelled some months after - - - 46
Trichiniasis - - - 276
Tricuspid valves, rupture of one of the musculi papillares of - - 73
Tubercle in lungs, dense deposit of, with dilatation of right side of heart - - - - 69
,, of the spleen of a young ourang 280
,, in the lower animals, casts of morbid specimens of - - - 280
Tubercular disease of brain, with loss of use of language - - 14
Tuberculous disease of the kidney 180
,, lungs of an antelope - - 279
Tumours, etc. - - 236-242
Tumour pressing on the spinal cord 21
,, small, within tympanum - 236
,, fatty, from the recto-vaginal septum 277
,, fibro-fatty, of the neck in a child, successfully removed - 236
,, fibrous, from near the angle of the lower jaw - - - 223
,, — three large, in ovarian cyst adherent to uterus - - 199
,, — of scrotum, involving the left testicle - - - 183
,, fleshy, of the thigh - - 237
,, gliomatous, of brain - - 23
,, hydatid, of liver threatening to burst; paracentesis; recovery 148
,, — of liver, bursting into bile-duct 160
,, — of the liver opening into the lung 154
,, lobulated mammary - - 240
,, medullary, of kidney - - 171
,, — of leg, from an infant - 238
,, melanotic of the orbit - - 235
,, (ovarian) see *Ovarian tumours.*
,, sebaceous, in the tympanum - 233

Tunica vaginalis, milky fluid from; galactocele - - - 184
Turbinated bones, necrosis of - 212
Tympanum, sebaceous tumours in 233
„ small tumours within - - 236
„ cicatrix of membrana tympani 236
Typhoid fever, large intestine from a case of - - - 127
„ — see *Enteric fever.*
Typhus fever complicated with diarrhœa, intestines from a case of 124
„ gangrene of entire penis occurring with - - - - 192
„ embolism of the iliac and femoral arteries in case of - - 93
Ulcer of transverse colon, communicating with the stomach - 142
„ large chronic, of stomach, and perforation of splenic artery - 137
Ulcerated cavity in the wall of the heart; death from meningitis 121
Ulceration of inner surface of cranium 4
„ chronic, of larynx - - 44
Ureter, malformation of, wasted kidney from - - - - 181
„ left, impervious, and right plugged at its extremity, in case of suppression of urine - - 176
Urethra, numerous spherical calculi passed by - - - 181
„ slitting up of, after amputation of penis, to prevent contraction of orifice - - - 192
Urinary deposits, pink lithate - 176
Urinary Organs, diseases, &c., of 164-183
Urine containing colouring matter resembling indigo - - 181
„ suppression of, for ten days; left kidney destroyed, &c. - 176
„ of intermittent hæmaturia - 168
„ see *Hæmaturia.*
Uterus, malignant disease of; secondary deposits in lungs - - 198
„ rupture of, in early period of pregnancy - - - 203
„ inverted, successfully removed by ligature during life - - 208
„ — protrusion of large mass from vagina, supposed to be an - 210
Valve, aortic, rupture of - - 77
„ mitral, aneurism of - - 91
„ — bony deposit in, with congenital malformation - - 89
Valve, mitral, *continued.*
„ — rupture of diseased, during violent vomiting - - 67
„ — ruptured chordæ tendineæ of 82
Valves, pulmonary, entire loss of two of the - - - 74
„ — congenital malformation of 81
„ — thickening of, in case of open foramen ovale - - 91
„ tricuspid, rupture of one of the musculi papillares of - - 73
Vascular System, diseases, &c. of 62-124
Veins, femoral and popliteal, thrombosis of, in case of typhus - 93
Vena cava, inferior, obliteration of 92
Vertebræ, lumbar, caries of, in case of paraplegia - - - 34
Vocal cords involved in epithelial cancer of epiglottis and pharynx 53
Vomer, necrosis of part of the - 212
Vomiting, rupture of diseased mitral valve during - - - 67
Weber (Dr. Hermann), kidneys with fibrinous deposits from embolism of renal arteries - - 166
Wells (Mr. Spencer), semi-solid ovarian tumour - - - 206
„ fatty tumour from recto-vaginal septum - - - 277
Wilks (Dr.), cyst in the cavity of the arachnoid - - - 6
„ disease of the trachea, probably syphilitic, opening into the aorta 52
„ entire loss of two of the pulmonary valves - - - 74
„ rupture of one of the aortic valves 77
„ rupture of aorta from injury - 79
„ strangulation of intestine by diverticulum ilei - - 126
„ large intestine from a case of typhoid fever - - - - 127
„ congenital syphilitic disease of the testes - - - 189
Windsor (Mr. Thomas), two cases of black cataract - - 230
„ *report* on ditto by Mr. Hulke 233
Wright (Dr. H. G.), *per Dr. Murchison*, encephalocele of the posterior part of the skull - - 35
„ pendulous growths, from surface of the body - - - 269

Printed by J. W. Roche, 68, Paradise Street, Rotherhithe.

RB
1
P4
v. 16

Pathological Society of London
Transactions

Biological & Medical Serials

PLEASE DO NOT REMOVE
CARDS OR SLIPS FROM THIS POCKET

UNIVERSITY OF TORONTO LIBRARY